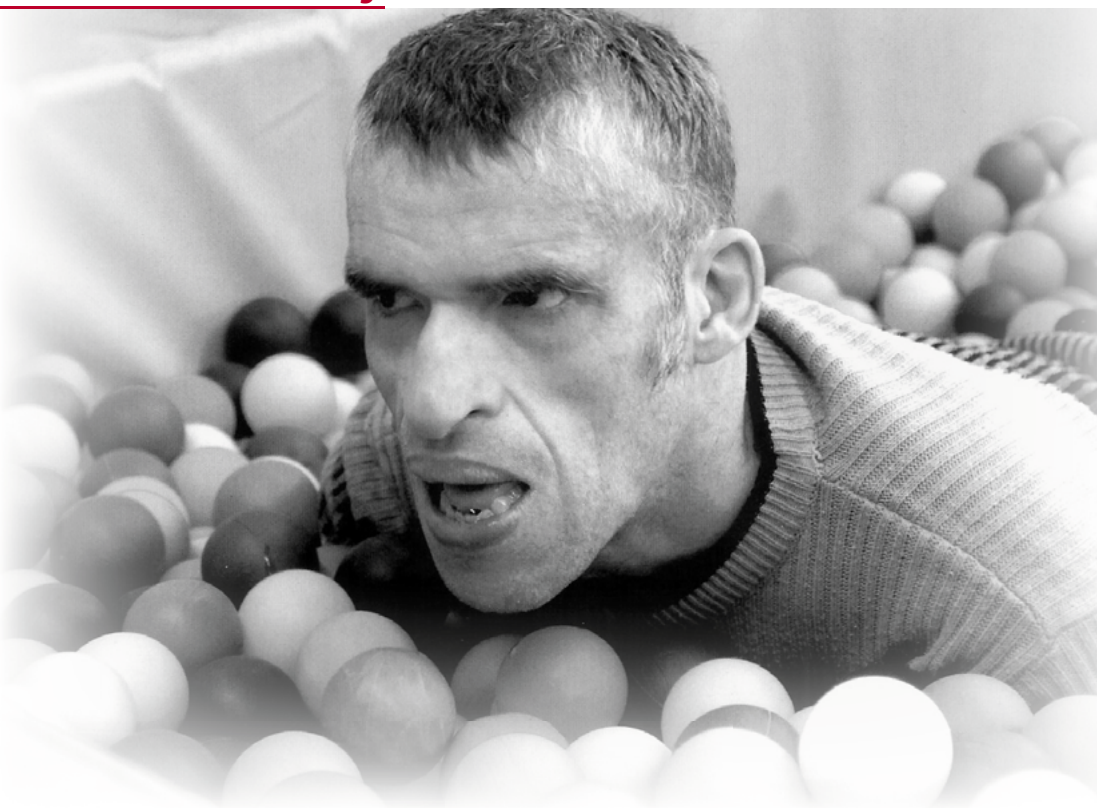


Germany



Care Work with People with Disabilities

Oberstufenzentrum Elbe-Elster



Lifelong Learning Programme

Education and Culture DG

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Care Work with People with Disabilities in Germany

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Introduction

Dear Student

A very warm welcome to Germany.

◆ *We are delighted you have chosen to come here for your practical placement and hope you have a worthwhile and interesting time.*

The purpose of this booklet is to give you an overview and insight into care work with disabled people in Germany.

This is a very interesting area to work in and there are new initiatives and opportunities developing all the time. Every effort has been made to provide you with up to date information, however you could be made aware and introduced to new legislation, policy and practice during your placement which may have been implemented since this booklet was produced.

There is a lot of information in the booklet which will be of use to familiarise yourself with prior to your visit, also it is hoped it will be a useful reference during your placement.

We wish you a pleasant and enjoyable stay in Germany and hope you have a successful practical placement.

Promoting the Status and Social Inclusion of People with Disabilities within EU

1. Rights, Status and Social Inclusion of People with Disabilities in the European Union

1.1 The United Nations

Universal Declaration of Human Rights

In 1948 The General Assembly of the **United Nations** proclaimed "**The Universal Declaration of Human Rights**" which is the most fundamental document that also defines the rights of people with disabilities.

All human beings are born free and equal in dignity, without a distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory which a person belongs to, whether it is independent, trust, non-self-governing or under any other limitation of sovereignty."

In 1971 United Nations' General Assembly issued "**The Declaration on the Rights of Mentally Retarded**

Persons" and in 1975 the "**Rights of Disabled Persons**". Both declarations included normalisation and integration as the guidelines. The aim put forward in these declarations is that of guaranteeing all people equal possibilities of participating in social life. *Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible."* (Rights of Disabled People 1975)

Furthermore, the **Rights of Disabled People** argues for their right to necessary services and social protection *"...disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible... and ...have the right to medical, psychological and functional treatment, including prosthetic and orthopedic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement*

services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration....

...have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment...”

The position of people with disabilities was kept in public awareness by several means. The UN proclaimed 1976 as the **International Year of Disabled Persons**, calling for an action plan at all levels, from international to regional, for the purpose of promoting the equalisation of opportunities, rehabilitation and the prevention of disabilities.

World Programme of Action Concerning Disabled Persons

After the International Year of Disabled Persons more extensive and specified development took place. The General Assembly formulated the **World Programme of Action Concerning Disabled Persons (1982)** to promote their rights and position in societies on a global level. The programme's agenda was more detailed and focussed. It included a broader approach with expressions such as the “*full participation*” of disabled people in social life and the development of “*equality*,” i.e. equal opportunities in a broad sense as well. The programme also defined key concepts such as “impairment”, “disability” and “handicap” – and prevention as the

strategic objective. Rehabilitation was also defined in a clearer way – as a set of services that function as measures in the facilitation of the disabled persons' full participation and equality. This action plan also put emphasis on education and employment, as well as on removing barriers that often manifest themselves as negative approaches to and attitudes towards this question.

The United Nations' World Programme of Action Concerning Disabled Persons was an action plan for Governments. To provide time for putting the Programme of Action into effect, the UN proclaimed the **United Nations Decade of Disabled Persons 1983-1992**. Governments could implement the Programme within ten years.

At the end of the Decade of Disabled Persons in 1992, the General Assembly proclaimed the 3rd of December as the **International Day of Disabled Persons**. To enhance public awareness the Day has varying themes on issues that are relevant to people with disabilities. **In 2007 the theme was “Decent work for persons with disabilities”.**

1.2 The European Union and People with Disabilities

◆ **The European Union** recognises the United Nations' rules on the Equalisation of Persons with Disabilities as the basis for the development of disability policy in Europe. In 2003 the Commission stressed its belief that the *“emphasis on the rights based approach to disability should be reflected in the evolution of an international human rights standard relating specifically to disability”*.

The EU has specific legal grounds upon which to act in respect to advancing disability rights. Article 13 of the EC Treaties enables the Community to combat discrimination on the grounds of disability. Articles 21 and 26 of the Charter set out the rights of people with disabilities. Article 26, in particular, recognizes *“the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community”* as a fundamental right.

The European Union Disability Strategy stresses the need for a renewed approach, focusing upon the identification and removal of various barriers that prevent disabled people from achieving the equality of opportunity and full participation

in all aspects of social life. However, the primary responsibility for action rests with the Member States. The Community Disability Strategy focuses on

- ◆ strengthening the co-operation between and within the Member States
- ◆ increasing the participation of people with disabilities
- ◆ mainstreaming Disability in Policy Formulation

2. The Concept of Disability in Germany

◆ Individual definitions for the term ‘disabled’ differ widely internationally. The World health organization (WHO) can thus only attempt to put together a rough definition.

For disability, the WHO always starts with three terms:

Impairment Shortcomings or abnormalities in the anatomical, psychical or physiological functions and structures of the body.

Disability Curtailments or defects in function due to injuries which hamper dealing with typical everyday situations or makes this impossible.

Handicap Disadvantage to a person due to an injury or other impairment.

Even when considered nationally, there are numerous approaches to defining the term ‘disabled’.

Ulrich Bleidick, university lecturer in educational science at the University of Hamburg, defined the term ‘disability’ as follows: *“Persons count as being disabled when, due to injury or impairment, their bodily, psychic or mental functions are affected to such a degree that their activities of daily life or participation in the life of society are hampered.”*

He thus differentiates between an injury or impairment and the resulting adverse social effect. Often, however, it is very difficult to prove that impairment exists, or it does not exist in a recognizable form although the person is socially disabled (as are some people with learning disabilities, for example). A social norm can therefore result in a disability.

For this reason, **Urs Haerberlin**, lecturer at the University of Freiburg in Switzerland, defines disability as follows:

“1. Disability can be seen as a limitation of the behavior of an individual, affecting his ability to deal with everyday life. For example, anyone bound to a wheelchair is limited in his ability to travel, and a person with a learning disability is limited in his ability to write and do arithmetic.

2. A disability can be understood as a limitation on the working of a social institution by an individual. For example wheelchair occupant limits the working of public transport facilities, or the person with the learning disability disturbs the working of the normal class.”)

The conditions and expectations imposed by society can thus lead to the limitations and disadvantages.

To be able to take advantage of certain financial relief possibilities, for example,

people with disabilities must first let themselves be stigmatized by society. It is therefore possible to read the following concerning disability in the **National Code of Social law** (BSHG) Paragraph 124 Clause 4, Sentences 1-4: *“...a not just temporary and considerable limitation of freedom of movement resulting from missing or dysfunction of limbs or for other reasons...there continue to be disabilities due to severe limitations of the seeing, hearing and speaking faculties which are not of a temporary nature and also due to severe limitations of mental or psychic faculties.”*)

In this case also, the social dimension of the term ‘disability’ is not addressed, only the impairment itself.

Disability is, however, also a **process term**, since a disability may disappear, due, for example, to a successful operation or appropriate pedagogic support. A disability can also be caused by an accident, or a progressive illness or insufficient treatment may make a disability worse.

A person with a disability is not necessarily disabled to the same extent in all areas of the life of society. Given the appropriate acceptance and empathy, he or she may be able to lead a life without disability within the family circle, but may be disabled in the school or profession. Even in quite specific living situations, the disability may play a greater or lesser role.

The term ‘disability’ is thus very complex and often serves only as a

simplification to identify a particular target group for the reason of medical, teaching or social intervention. It should be noted in this context that the same disability may be assessed differently by different specialists.

In **medicine**, for example, there is still no clear definition. The National Working Council for Rehabilitation formulates it so:

“This is a general term lying in the anatomical-physiological field, which is complex and often difficult to differentiate from various neighboring fields. Adding to the difficulty of defining this fuzzy term ‘disability’, is the fact that the terminology is insufficiently capable of delineating all of the issues giving here or of illustrating all the various levels at which ‘disability’ comes into play.”)

In **teaching**, according to the Education Commission of the German Central Advisory Council for Education, all children, young people and adults should be treated as being disabled who are:

“..limited to such a degree in their learning ability, their social behavior, in spoken communication or in their psychomotor capabilities that their participation in society is greatly hampered. For this reason, they require special learning support. The disability may be caused by the limitations on seeing, hearing, speaking, standing and movement functions, intelligence, emotions, external appearance as well as certain chronic illnesses. Often, multiple disabilities are present...”

There exist categorizations according to:

1. Causes

How the disability occurred. This is important for disadvantages compensation and similar.

- ◆ Congenital
- ◆ Accident
- ◆ Armed services/war injuries
- ◆ Other causes

2. Kinds of disability

In the German-speaking region, the term 'disability' is split up farther into the following subgroups:

- ◆ Mental handicaps
- ◆ Hearing impairment (deaf + hard of hearing)
- ◆ Physical disability
- ◆ Learning disability
- ◆ Multiple disabilities
- ◆ Severe disability
- ◆ Extremely severe disability
- ◆ Sight impairment (blindness + impaired vision)
- ◆ Speaking disability
- ◆ Behavioral disability

In many other countries, this split is not as detailed; often there is only talk of physical disability and mental handicap.

3. Consequences

The consequences resulting from a disability: This is particularly important for the groups of professionals who work with these people.

- ◆ Requires special school
- ◆ Is helplessness
- ◆ Requires special home care
- ◆ Requires rehabilitation

Disabilities can, no matter how severe they are, be experienced very differently at a subjective level. Moreover, it is important to know that the understanding of the term 'disability' has developed in the course of human history and is, and will be, subject to further developments because those affected feel stigmatized, and also because those working with disabled persons no longer accept this term.

2.1 Definition of Physical disability

◆ Physical disability is a collective term for several diverse symptoms and degrees of physical impairment resulting from damages of the nervous system, skeleton, muscles and body and their functions. The most common symptoms of physical disabilities are:

- ◆ damages of the nervous system, e.g. brain and spinal marrow
- ◆ cerebral palsy
- ◆ spina bifida
- ◆ hydrocephalus
- ◆ infantile and other form of paralysis

2.2 Definition of Multiple Disability

◆ The term "Multiple Disability" refers to a complex structure of two or more impairments. It is not to be understood as the sum of different disabilities but as a complicated structure of several elements. The problem is that the

elements often affect each other in an indefinable way. The following table gives an overview on kinds and degrees of disabilities.

Kind of Impairment	<i>Degree of Impairment</i>			
	<i>Slight</i>	<i>Medium</i>	<i>Serious</i>	<i>Extreme</i>
<i>Auditive</i>		<i>Hard of hearing</i>	<i>Deaf</i>	Serious Multiple <i>Disability</i>
Visual		Defective Vision	Blind	
Cognitive	Weakly gifted	Learning Disability	Mental Disability	
Motoric	Physical Disability			
Speech	Speech Disorder			
Behaviour	Behavioral Disorder			

The term “Multiple Disability” is used to mark a considerable need of help and assistance.

2.3 Definition of Learning Disability

◆ Learning disability cannot easily be defined with sociological, psychological and medical characteristics. It is more a combination and structure of all characteristics affecting each other in a way that the persons concerned are not able to reach the learning objectives of the regular developed persons. They therefore need special help and assistance in achieving the targets.

3. Changing Perspectives in Germany

◆ The significance of people with disabilities has had a changeful past that has been, and will continue to be, heavily influenced by the norms and values of the societies concerned.

At the beginning of the Twentieth Century, disabled people were often isolated and hidden in institutions. They were judged to be inferior and as not being part of society. It was the spirit of the age that determined this viewpoint and it was shared, and scientifically established, by leading figures in healthcare. This is how Darwin's theory of evolution increasingly gained in importance in the Nineteenth Century, so it is not surprising that at the start of the Twentieth Century, decisions on "worthy of life" and "not worthy of life" were already being made based on cost-benefit analyses.

It was on this fertile ground that Hitler was able to implement his "eugenic measures" in the Third Reich. From 1939 until the end of the war, ethnic cleansing was carried out by killing children, including many thousands of children with disabilities. The designation T4 was the name used to camouflage the mass killing of disabled or ill people. These killings were legitimized by the "Law for Prevention of Genetically Deficient Offspring" of July 14, 1933. This law was followed by:

- ◆ The euthanasia program for the "incurably ill"
- ◆ The direct eradication of undesirable peoples and invalids by means of "special treatment"
- ◆ Experimental preliminary work for mass sterilization

Doctors, as part of the health services, and remedial carers were involved in all of these measures.

Forced sterilization continued to be practiced after 1945. The picture first changed in the 70s in the course of reform in psychiatry. The old institutions were, in many Federal States, abandoned in favor of facilities with close links to the community. Facilities for disabled people were reduced in size and integrated into existing communes.

In any case, society underwent a period of social rethinking in the 60s. People with disabilities should no longer be pushed to one side, should no longer be simply cases that had to be cured for, but people who, with their handicaps, had to be taken seriously. The catalyst for this was the shock over the "thalidomide catastrophe". Several thousand children were born with severe deformities because their mothers had been taking sleeping tablets containing thalidomide, first approved in 1957. For the first time, disability was not seen as one's private

fate, but as a task which society had to deal with.

With regards to normalization, empowerment, integration and inclusion, society's views of people with disabilities changed decisively. The person, not the disability, was placed at the forefront of attention. In consequence, it was seen that people with a disability want to follow a self-determined, independent and normal way of life as much as they possibly can. This caused a further rethinking process. A disability is now much more seen as the result of an interplay of individual possibilities and social conditions and expectations. One is not a disabled person, one becomes a disabled person. Of this insight has led to important shifts of emphasis in remedial and teaching work. Based on the principle that it is normal to be different, the goals of current work are to remove obstacles, eliminate barriers, disarm prejudices and found a society in which people with disabilities, exactly the same as people from other cultures, are first seen for what they are – people who enrich the world, filling it with variety and a wonderful fascination.

What effects do these changes have on the remedial care profession? In connection with new legislation (SGB IX) and the introduction of personal budgets, there is increasingly talk of a paradigm change. From one perspective, the new conditions will

considerably affect the requirements level for remedial teachers. The buzzwords for this paradigm change are self-determination instead of determination by others, inclusion instead of exclusion, and integration into the community, with community care or participation as the goal to be aimed for. From the professional perspective, the personal budget can be better regarded as lying in a higher degree of self-determination and the creation of individual choices that meet needs. In this context, care must be taken that a society does not arise which consists of two classes, split between so-called 'budgetable' persons and those who are denied the budget because of possible extra cost.

Forecasts indicate that in future increasingly more people will be dependent on assistance and care. In particular, the number of people with very heavy disability, or multiple disabilities who are dependent on care and assistance from outside the family circle will increase. In addition, disabled people will lead to drastic changes in the age structure. This will mean that disability assistance will increasingly be linked to old age care.

Rehabilitation assistance will have to develop an independent participation-oriented profile in order not to be seen by the public and those bearing the cost as simply a subservient part of the world of caring. In the long term, not much will change in the usual

performance-related (not participation-related) disability insurance idea. Much-needed extension of the care concept and its performance-oriented safeguarding simply cannot be financed. There is, moreover, an image problem concerning the prestige of those engaged in care work. Although the image of those engaged in short-term care is highly regarded, for those involved in long-term care work it is rather low. This has not been helped by the publicizing of care scandals.

Assistance requires a certain observational attitude, an ability to pause and hold oneself back, and focused action. This is because doing something for somebody is faster than doing something with somebody. In this context, the question of whether the term 'remedial care' is sufficiently up-to-date remains to be answered.

This perspective implies that we must say goodbye to the principle of holism. Holism means that all the attendance and care needs of the disabled person are supplied from a single source, and furthermore that all of these needs are immediately linked to one another.

Financing will also change its perspective: Up until now the facilities have basically been financed by cost scheduling. This will successively be discarded in favor of cash payments with which those affected can themselves purchase 'assistance'. An ongoing process of changing financing

of the object to financing of the subject is to be expected. After agreeing a budget, an agreement on aims will be necessary before taking advantage of services. This will define what kind of assistance is required, how comprehensive this is expected to be, and by whom, or by what profession the service is to be supplied.

This places new requirements on the profession of remedial care, both on the task profile and on the requirements profile, as well as planning and setting up of work and a needs-based determination of working times. Remedial carers have on the one hand to widen their operational business scope, while on the other they must simultaneously relinquish a part. As professionals, they coordinate assistance and care and are responsible for the planning and implementation of assistance. They also check, however, whether the necessary and right services have been provided by other staff groups. This means that they have a great deal of responsibility for checking the quality of the process, but even more for checking the quality of the result.

In short, the primary task will be managing assistance for those with disabilities while increasingly leaving the actual assistance itself to other groups of staff.

Case:

In the year 2000 the German family Meier have a baby boy Felix who later on is diagnosed to have an average-level CP together with a minor mental disability. Felix will need in future a wheelchair to help him with mobility and those ones who are not acquainted with him will find it slightly difficult to understand his speech. His parents are concerned about his future: what chances will their son have for a meaningful andl life in dignity – and how will Fredrik manage in society once becoming an adult?

4. How to meet the needs of people with disabilities

◆ Developmental diagnosis is an awareness process. It is a way of becoming aware of the other person, and by doing so, also the own person. Becoming aware is more than knowing. Awareness searches for the essentials of a person and his state of development. Which tasks does this person have in his own life, and which tasks do I have? To be on the move means that one must remain aware of all situations of a temporary nature and remain hopeful, even in situations which appear to be hopeless. No one can live without hope.

Diagnosis is understood to be the art of correct preparation and implementation of the diagnostic investigation and includes, as a prime element of decision-making, both 'awareness' and 'understanding'.

Developmental diagnosis requires an indication, i.e. an explanation that justifies the specific case (not everyone requires remedial teaching). It is created on the basis of medical and psychological data, one's own experiences and observations, and serves as the basis for understanding, justification, and the deriving and implementation of learning goals and measures. As well as observations and perceptions, a case history, study of any existing reports, test procedures and interviews, it comprises the formulation of goals for support of the disabled person. For this reason it always relates to the development of the disabled person.

It should be noted that all diagnoses are themselves a question of the subjectivity of the tester.

The diagnostic process can be shown in the following diagram:



If need be the process has to be repeated.

The goals of all developmental diagnoses are aimed at gaining a better person- and situation-related understanding of the experiences and behavior of the disabled person, optimization of awareness of the individual development potential and its limits and support possibilities, as well as improvement of the personal and structural prerequisites for integration into, and participation in, the life of society. The goal is not fixed determination or even social exclusion, but optimization of the awareness of individual development potential, its limits and support possibilities. Developmental diagnosis is meant as a contribution to understanding sensibilities in spite of the more difficult living conditions of disabled persons.

Before any developmental teaching is undertaken, the **case history**, the record of all reports on a person's life, must be studied. This gives a picture of the personality of the disabled person regarding his behavior towards his most important contact persons, as well as his subjective ability to deal with social relationships, events and experiences. The case study gives a glimpse of the previous development of the disabled person, his family situation, his interests and habits.

Observation is the main non-standardized diagnostic procedure. Observation from the developmental aspect is a process of becoming aware of the total personality of the disabled

person. The results of observation are meant to help understand a disabled person's behavior and actions, in order to be able to develop adequate assistance possibilities. If the organizational structures of a disabled person differ too widely from general organizational structures, faulty judgments and excessive demands may result. The more detailed the setup of the observation, the more exactly can the total development of the disabled person be assessed.

Possible areas of observation can be:

Gross motor skills, fine motor skills, bodily perception, tactile-kinesthetic perception, auditory perception, visual perception, speech, cognition, attention and concentration, social-emotional area, assessment of family situation and social contact.

A further possibility in developmental diagnosis is offered by **test procedures**. Test procedures have here a specific, but mostly limited, importance, because it is not possible to conduct tests on many of the people whom we care for and support. The implicit prerequisites are often not present. The specific testing ability must be checked in advance when dealing with disabled persons.

Standardized test procedures are clarification techniques carried out according to certain rules. These are mostly calibrated testing procedures aimed at certain capabilities

(intelligence, concentration, motor skills, etc.) and generally used under the premise that deficits can be recognized. The goal is to remove, or at least lessen, these deficiencies. This implies that the whole person is broken up into 'ill' parts. Standardized tests are subject to value criteria.

Remedial care workers themselves will most probably not carry out such tests, but will come into contact with them and their results through cooperation with psychologists, doctors and therapists.

5. Legislation

◆ German legislation regulating the affairs of people with disabilities

The Basic Constitutional Law of the Federal Republic of Germany (1994) declares that all citizens in Germany are equal. Nobody is to be discriminated against because of his or her disability. The Constitution furthermore stipulates that everyone has the right to education.

The Constitution of the State of Brandenburg defines the position of people with disabilities in society as well as their rights and duties. The State of Brandenburg is liable to ensure the right of social security in cases of illness, accident, invalidity, disability and need of care. Social security is supposed to enable a life in dignity. People in need, who cannot lead an autonomous life in dignity have the right to claim social benefits. The general principle is that all people are equal and entitled to the same services regardless of economic and social status.

The Code of Social Law has first been established in 1975. It sums up all laws concerning insurances and social services. The Code of Social Law has constantly been modified and supplemented according to society's reality. This kind of legislation is of great advantage for people with disabilities as it not only regulates their financial support but enables them to develop their personality within society.

The Law to Assimilate People with Disabilities in Status (2002) stipulates to abolish and avoid all discrimination against people with disabilities, guarantees their equal participation in social life and enables their autonomous living according to their special needs.

6. Financial Support

◆ Persons who are disabled, or who are threatened with disability, receive assistance in accordance with the Code of Social law and in accordance with the applicable laws of those authorities responsible for rehabilitation in such a way that their self-determination and equal participation in the life of society is encouraged, and disadvantages are avoided or combated.

According to Clause 6 of Code of Social Law IX, responsible **rehabilitation authorities** include:

- ◆ Statutory health insurers
- ◆ Federal Employment Office
- ◆ Statutory accident insurers
- ◆ Statutory pension insurers
- ◆ Public youth welfare authorities
- ◆ Social welfare authorities

According to Clause Three of this law, prevention is highest priority of service to be offered.

To keep administration time as short as possible given the numerous authorities responsible, Clause 14 of Code of Social Law IX stipulates that any application handed in to an authority which is not responsible must immediately be handed on to the authority responsible for supplying the service. In accordance with Paragraph 22 and following of Code of Social Law IX, district service centers offer advice and support on requirements concerning the provision of services, the granting of these,

and making and forwarding of an application.

Groups of services:

1. Medical rehabilitation services according to Paragraph 22 and following, Code of Social Law IX

- ◆ Early recognition and support
- ◆ Medications and dressings
- ◆ Speech and occupational therapies
- ◆ Psychotherapy and treatment
- ◆ Stress testing and work therapy
- ◆ Activation of self-help potentials
- ◆ Advising relatives
- ◆ Training in practical living capabilities
- ◆ Treatment for illness, etc.

2. Services for participating in working life according to Paragraph 33 and following, Code of Social Law IX

- ◆ Help in finding or retaining employment
- ◆ Preparation for employment
- ◆ Occupational adaptation and further education
- ◆ Occupational training
- ◆ Bridging benefits according to clause 57 Code of Social Law III
- ◆ Participation of integration special services as part of their duties in accordance with Clause 110 Code of Social Law IX
- ◆ Costs for accommodation and board, when services are rendered outside parents' house

- ◆ Training course costs, examination fees, learning materials, work clothing, work equipment
- ◆ Vehicle assistance according to the Vehicle Assistance regulations
- ◆ Costs of necessary work assistance
- ◆ Tools and aids
- ◆ Services in disabled persons workshops: Services supplied for entry procedure, vocational training area and work
- ◆ Work assistance benefit in addition to payment of 26 €, etc.

3. Upkeep and other supplemental services according to Paragraph 44 and following, Code of Social Law IX

- ◆ Illness benefit
- ◆ Injury benefit
- ◆ Change-over benefit
- ◆ Educational benefit
- ◆ Upkeep benefit
- ◆ Travel costs
- ◆ Work or home help, child care costs, etc.

4. Services for participation in the life of society according to Paragraph 55 and following, Code of Social Law IX

- ◆ Remedial teaching services for pre-school children
- ◆ Support help for understanding of the environment
- ◆ Help in obtaining, fitting out and keeping a residence
- ◆ Supervised home
- ◆ Help in participating in social and cultural life, etc.

The services named may be delivered in the form of a personal budget; from 01.01.08, disabled persons have a right to this and can receive the necessary financial assistance to be able to purchase the necessary aids themselves.

The degree of help needed is determined in a cross-authority procedure and supplied by the social services department. Usage is determined by a goals agreement with the social care authority responsible. Checks are possible, but not in the form of 'spoon-feeding' the recipient.

Disabled persons can claim rehabilitation assistance from the social services department in accordance with Paragraphs 53 and following, Code of Social law XII.

This is given when it is not expected that the claimant or the caring group will be able to supply this.

This would be the case when during the period of need, the monthly income does not exceed a limit in accordance with Paragraph 85, Code of Social law XII.

This is calculated on the basis of:

- ◆ An amount double the basic standard rate - currently 694 €
- ◆ Accommodation costs
- ◆ A family supplement of 70% of the basic standard rate - currently 243 € for each further person in the caring group or for persons eligible for care

When the claimant also meets the requirements of Paragraph 53, Code of Social Law XII, the person receive rehabilitation assistance such as:

- ◆ Assistance in suitable school education
- ◆ Assistance in school training for a suitable occupation
- ◆ Assistance in vocational training for another suitable activity
- ◆ Services for rehabilitation and participation in working life according to Code of Social Law IX

Blind persons may apply for blindness assistance according to Paragraph 72, Code of Social Law XII.

Code of Social Law XI services for persons in need of care are supplied by the public health care authority

(not a Code of Social Law IX supplier of rehabilitation services)

Persons in need of care according to Paragraph 14, Code of Social law XI, are persons who, due to a bodily, mental or psychic illness or handicap, need considerable, or major, help in carrying out normal and recurring everyday tasks for a period of at least six months. Normal and recurring everyday tasks are personal hygiene, nutrition and mobility, and in addition home care. Claimants are classified in one of three levels by the medical services of the health insurers depending on the degree of care needed.

Benefits:

Financial benefits for outpatient care when self-obtained:

- ◆ Care level 1 205 €
- ◆ Care level 2 410 €
- ◆ Care level 3 665 €

Code of Social Law XI is to be amended in 2007, with financial benefits for outpatient care being increased by 30 €. If the benefits are supplied as benefits in kind, there is an entitlement to home care of:

- ◆ Care level 1 384 €
- ◆ Care level 2 921 €
- ◆ Care level 3 1,432 €
- ◆ According to paragraph 38, Code of Social Law XI, a combination of financial benefits and benefits in kind is possible.

For inpatient care, the benefits are as follows:

- ◆ Care level 1 1,023 €
- ◆ Care level 2 1,279 €
- ◆ Care level 3 1,432 €
- ◆ Accepted case of hardship 1,688 €

Further services according to Paragraph 28, Code of Social Law XI

- ◆ Home care when carer cannot attend
- ◆ Care in kind and technical care materials
- ◆ Day care and night care
- ◆ Short-term care
- ◆ Care courses for relatives, etc.

7. Services for people with disabilities in Germany

◆ Services for people with disabilities are of various kinds in Germany. Naturally, people with disabilities have access to all General and Public Health Services like:

- ◆ Family Practitioners
- ◆ Pharmacy
- ◆ Emergencies
- ◆ Hospitals
- ◆ Specialized Hospitals
- ◆ Ambulance
- ◆ Etc.

Additionally, a large specialized sector of services has been established in Germany. They are basically divided into three different groups of services:

Outpatient Services

- ◆ self-help groups
- ◆ advice facilities
- ◆ family supporting services
- ◆ independent living

Partly Inpatient Services

- ◆ early support and advice facilities
- ◆ integrative day care centres
- ◆ schools for people with special needs
- ◆ vocational training centres
- ◆ adult education centres
- ◆ workshops for people with disabilities
- ◆ social-psychiatric institutions

Inpatient Services

- ◆ homes for children, youths and adults
- ◆ special hospitals

- ◆ facilities for rehabilitation
- ◆ assisted forms of living

People with disabilities have a right to self-determined participation in the life of society. In so doing, they are supported by a system of services that takes their special needs into account. Help is aimed at fighting off the disability, remedying it or lessening its degree. This is a help to self-help and not a handout. It must be commensurate with the individual's own need, taking the wishes and specific living situations of disabled people into account.

The institutions responsible for the social services system are health, pension and accident insurers, the Federal Employment Office, the Youth Welfare Office and others. The social concept contains both preventative and rehabilitation measures. Preventative measures include free early recognition examinations. If it is found that the child has a health problem, early treatment and support in special facilities is possible.

Disabled children should, as far as possible, attend general nursery schools and elementary schools if they can receive a form of care appropriate to the nature of their disability, such as facilities designed for use by disabled

persons and specialized staff. In addition there are special schools for children and young people with a mental handicap, behavioral disorders, and bodily, speech, learning or psychic disabilities. In general, the duty of disabled children and young people to attend school ends when they reach 21. The type of school they must attend is decided by the local school authorities on the basis of a pedagogic-psychological report after having heard the health authorities and the parents.

Since not every kind of profession is suitable for people with a disability, the choice of profession is especially important. When doing so, it is important to assess the current and future services situation correctly. Career advisers, or measures taken in preparation for commencing vocational training, can be helpful here. There are various financial support possibilities for trainees who are disabled and for the employer. All the assistance necessary to ensure that a disabled person can continue to earn a living or resume earning a living, can be given in the course of vocational training. If disabled persons cannot be employed as part of the general work force, they can be given a place in a disabled person's workshop.

8. Working in different care settings

8.1 Ethics in care work

◆ Remedial carers are professionals trained as social care teachers and carers who are active as providers of **assistance, advice, companionship, care** and **education** to disabled persons in both the outpatient and inpatient areas. They work in cooperation with other professional groups and services and jointly decide on goals, content and forms of treatment on the basis of knowledge gained from modern theories and methods and how these are used. A holistic form of assistance based on the individual needs of the disabled person forms the basis of the daily work. Remedial carers are persons who are trusted by the disabled patient. An internal debate over one's own picture of oneself is a particularly important and fundamental requirement for this profession. The main tasks of a remedial carer vary according to the type and degree of disability. This assumes that the carer has learned to correctly assess disabilities, their causes, and their effects, to recognize existing capabilities and powers of the person, and how to activate and give help necessary.

The understanding of **assistance** or **support** relates to the right of free development of the personality anchored in the Constitution. The task of the remedial carer is to recognize the capabilities of the disabled person

and create ways in which that person can develop using all of his or her capabilities. This is the only way to lessen, prevent and finally overcome isolation, achieve a high degree of self-realization, self-determination and social integration. Support must be of a restrained nature while often providing protection against excessive demands.

Advising includes giving advice on all practical questions of daily life and on legal matters in close cooperation, but also on sensitive questions arising between people. The basis of advising is the normal chartered rights of a disabled fellow citizen.

Life counseling is the responsibility to offer a person all the help required in order that the person can face the world, discover it and connect with it – otherwise it remains closed to the person concerned. This includes perception of the real world and the person's relationship to himself, his body and his fellow humans. **Life counseling** is not paternalistic, but an enrichment where otherwise a disadvantage is to be expected due to a defective view of the world and difficulties in coming to terms with it. Life counseling must be carried out in a sensitive fashion; it demands participation in the life and experiences of the other. This means being attuned to that person. **Counseling** is more than just satisfying needs.

The **educational process** continues throughout a person's lifetime.

Education helps increase a disabled person's autonomy and emancipation. It also implies help in upbringing and encouragement. Education builds on the existing abilities of the person and attempts to differentiate and enrich these. This demands a good observational talent for the needs, capabilities and preferences of the individual, to be able to enrich these with educational offerings. In addition, this requires methodical, reflective treatment on the part of the remedial carer. The prerequisite of an educational process is first and foremost mutual trust and experiencing of a positive social relationship.

Care includes overall **personal hygiene**, and cannot be reduced to just the care and treatment of 'sick' people. **Care** also looks at the welfare of the whole person including his entire bodily and psychical condition (including his life as a social being).

Holistic care concentrates on increasing the quality of life to give the person the greatest feeling of well-being possible. This comprises all areas of human life, including sleeping, personal hygiene, nutrition, clothing, movement, living conditions and the encouragement of social relationships.

Because working with disabled people encompasses all aspects of life and can be carried out in a wide variety

of facilities and fields of work, the following presents the daily routines of typical practical facilities.

8.2 Working in an inter-disciplinary early support and advice facility

◆ Early support is the earliest form of aid for a disabled child, one threatened by disability or suffering from delayed development or developmentally handicapped children from birth up until 6 years of age or until enrolling in elementary school. Early support is tailored to fit the individual needs and possibilities of the child concerned. Here Felix will be supported developing his psycho-motoric skills. Early support and advice facilities are mostly a part of integrative day care centres (see 8.3)

Early support offerings and their content:

- ◆ Initiating play
- ◆ Encouraging play
- ◆ Senses training
- ◆ Concentration and perception training
- ◆ Speech initiation
- ◆ Guiding and advising parents
- ◆ Occupational therapy
- ◆ Relaying medical, psychological, therapeutic and logopedic measures
- ◆ Psychomotoricity
- ◆ Movement games

Outpatient and mobile early support

Outpatient early support takes place in an early support facility. Many parents use this opportunity to come into contact with other affected families. Mobile early support carers come to the home, into the trusted environment of the child or work with the child in the nursery school he visits.

Remedial carer responsibilities in an early support facility:

- ◆ Preparing support specifically for the individual child, taking the support plan into account
- ◆ Giving the support
- ◆ Evaluating the support (concentration, independence, speech, etc.)
- ◆ Participating in initial and ongoing diagnoses
- ◆ Observing the children
- ◆ Participating in parents' meeting on the subject of "Development of the child".

8.3 Work in an Integrative Child Care Centre

Felix'Early Childhood

It is essential to start therapies and assistance as early as possible to guarantee a successful rehabilitation. As cerebral palsy always affects the whole personality and all learning processes a holistic view

on Felix and his social settings is necessary. Therefore Felix and his parents will not be confronted with different specialised therapists whose work will have to be co-ordinated, but a therapeutical and pedagogical institution like an integrative child care. Felix will take part in the normal routine of the child care and have special therapeutical sessions. Felix is supposed to become more attentive and motivated with respect to his surroundings and to start communicating with the other children. Furthermore there will be a counselling for his parents.

The work in an „Integrative Child Care Centre” basically focuses on the integration of children with and without disabilities. They are supposed to live and learn together. The work differs from that in a regular child care centre in the following aspects:

- ◆ smaller groups with specially trained educators and carers
- ◆ rooms are arranged to meet the needs of children with disabilities
- ◆ care plans for the children with disabilities
- ◆ interdisciplinary teamwork with ergotherapists, physiotherapists, logopedists etc.

The major targets of the work in an integrative child care centre are:

- ◆ children with and without disabilities should play and learn together
- ◆ children should learn to accept each other and develop empathic understanding

- ◆ support integration and avoid segregation
- ◆ increasing independence and responsibility.

The children are the centre of all work in an integrative day care centre. It is the educator's duty to assist and support the children, observe their developmental progress, organise activities with and for them and experiment and learn together with the children. The educator assists in developing the children's social and emotional competences, their creativity, responsibility and autonomy. They support the children in exploring their surroundings and developing their learning competences. All work is based on the individual development of each child. Basic principles of the educator's work are partnership, trust, reliability, patience and mutual respect.

The daily routine in an integrative child care is as follows:

- 06:00 – 09:00 am Individual arrival of the children
- 07:30 – 08:30 am Breakfast and hygienic measures
- 09:00 – 11:15 am Free play: children choose partners, materials and games autonomously; educators watch children's developmental progress; projects and pedagogical offers according to children's interests
- 11:15 – 12:15 am Lunch
- 12:15 – 01:30 p.m. Midday sleep
- 01:30 – 05:00 p.m. Outdoor and indoor activities; coffee break; children

are picked up by their parents at individual times

05:00 p.m. Integrative day Care centre closes

8.4 Daily routine of a remedial teacher in a special school

Felix at School Age

Felix has now reached the school age. He and his parents have to decide which school to attend. Felix can either go to a school for children with special needs or attend the regular primary school. In the school for children with special needs Felix will be supported by a team of specially skilled teachers, social workers, therapists and remedial carers. The disadvantage is that he will be separated from the friends he made in early child care. Thus his parents should try to find a place for him in a regular primary school. This can be a difficult and bureaucratic process. It has to be made sure that there is special equipment for Felix like mechanical and electronic devices. Additionally, a specially skilled teacher and small learning groups are essential for Felix. Another problem can be the fact that Felix is supposed to achieve the same goals like the children without a disability. On the other hand it is important for him to learn that he is an accepted part of his social surroundings. This will lead to an increasing independence.

The remedial teacher's day starts at 7:30 a.m. with picking up the schoolchildren from the taxi rank at the school parking lot. Then the schoolchildren, the teachers and the trainees go to their respective classrooms. Before scheduled classes commence, a morning circle is held. The remedial teacher has here the task of encouraging, through short discussions, the tasks, communication and social behavior of the schoolchildren. Trainees or teachers then accompany the schoolchildren to their individual courses, which are set up according to the resources the schoolchild requires. During tuition, the remedial teacher has both a helping and supporting function (for example, guiding someone's hand when writing). The tuition hour finishes at 8:45 a.m. The schoolchildren, teachers and trainees return to their classrooms.

There is now a morning break. The children attending the special school set the breakfast table with the help of the remedial teacher and are also responsible for clearing up. The schoolchildren, teachers and trainees take breakfast together. Children who are physically handicapped are helped to eat by the remedial carer.

After breakfast there is a play break, during which it is the duty of the teacher to watch over the children and occupy them with playing games. The break ends at 9:45 a.m.

The schoolchildren now participate in support activities for two hours, with the remedial teacher leading the way, for example in community singing.

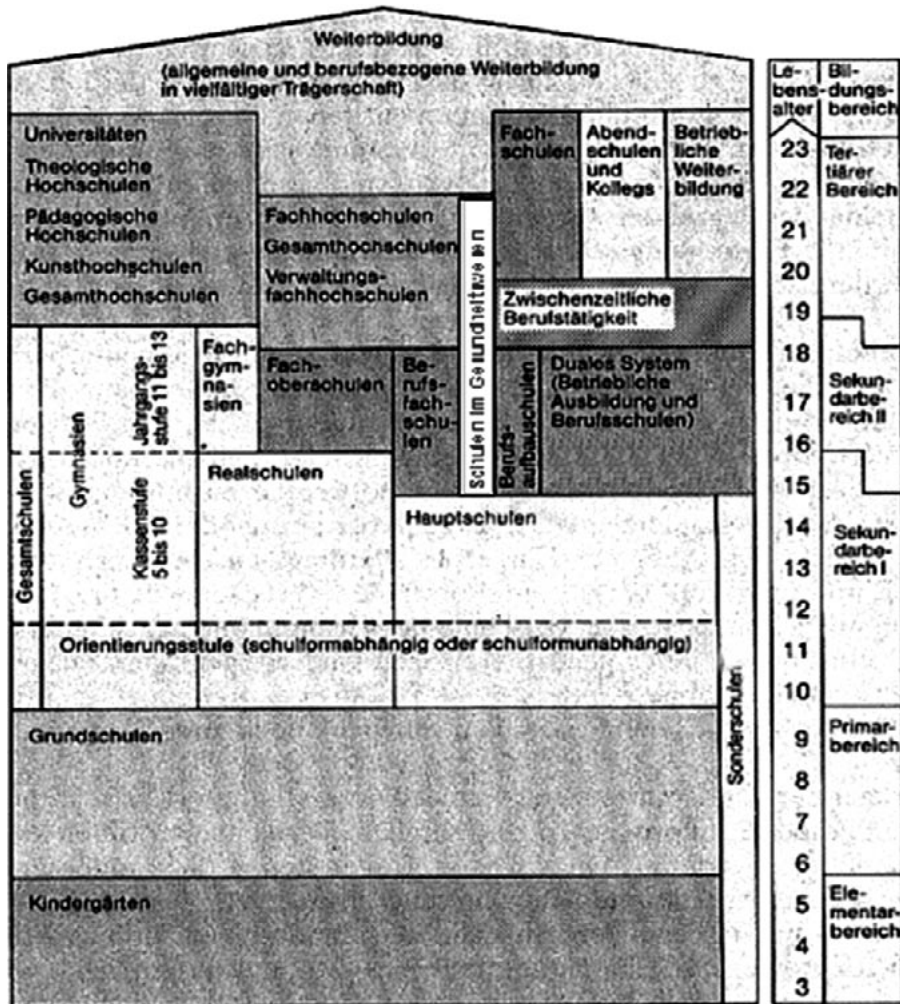
A joint midday meal is served at 11:45 a.m. Once a week the schoolchildren prepare a simple meal themselves with the aid of the teacher.

From 12:30 on, schoolchildren with a physical or mental handicap can take part in the play break, while the other children take the opportunity to relax. The remedial teacher can contribute by utilizing basal stimulation.

After the play pause, the schoolchildren start their core elective subjects, for example, circus, flute tuition or sport, in which trainees and teachers participate.

The remedial teacher brings the schoolchildren back to the taxi or to the after-school play club at 2:45 p.m., concluding the remedial care day.

9. Vocational Training



Skills

Personal skills designates the readiness and ability, as an individual, to explain, think through and assess opportunities for development, demands and limitations in the family, profession and

public life, including development of one's own talents and setting up and maintaining one's own plans for life. It includes personal characteristics such as independence, reliability and awareness of responsibilities and duties.

It particularly includes the development of thought-through ideals and self-determined loyalty to the corresponding values.

Social ability designates the readiness and ability to construct and live out social relationships and register affections and tensions, and the ability to discuss and agree rationally and responsibly with others. This particularly includes the development of social responsibility and solidarity.

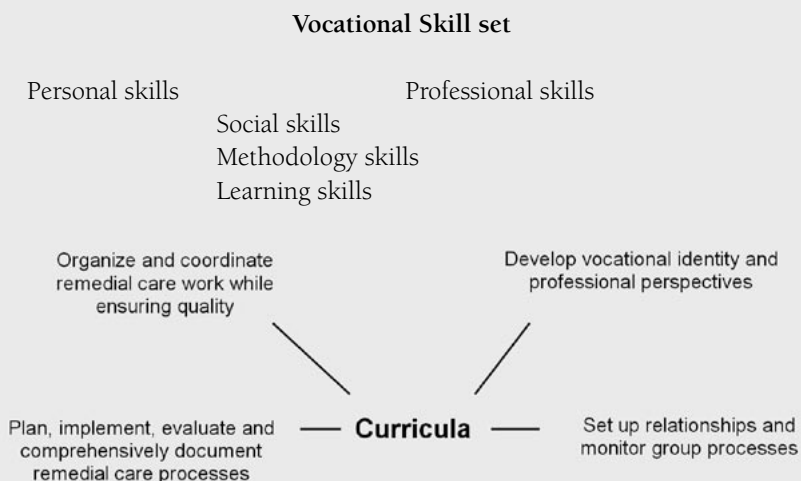
Methodologies and learning abilities are born from a balanced development of these three abilities.

To achieve these goals, present guidelines lay down **two measurements**:

- ◆ The central didactic measurement of this model is given by the **curricula**. They structure specific lessons as thematic units and represent the vocational areas involved.
- ◆ In the schools, individual learning conditions must be worked out that include vocational decision-making skills and permit problem solution and learning processes targeted towards ability to make such decisions.

The following structural model shows the relationship between curriculum and skill set.

Structural model for implementation of the curriculum concept in the remedial care vocational college



10. Employment Opportunities

◆ The remedial carer is responsible for the pedagogical and care assistance of people with physical, psychical, mental and learning disabilities. They are mostly employed in different care settings supporting the clients to meet the demands of their daily life. They work mainly in institutions like day care centres, day nurseries, living and charitable homes. They can as well work in outpatient social services, counselling facilities and hospitals for prevention and rehabilitation. Furthermore, they are concerned about the pedagogical organisation of leisure time in schools for children with special needs. Sometimes they are employed in private households as child carers. Depending on the age, work experience and place of work as well as the service provider the salary can differ from about 1300 Euro to 1600 Euro a month.

Appendices

1. Placement reports by students

Daily routine in a home for disabled persons

Dayshift commences at around 6 a.m. in the morning, with a shift handover. Then the breakfast table is laid for the residents going to the workshop or the school. These are then woken and help is given in washing und dressing. Breakfast is served after the morning ablutions. It is the task of the remedial carer to help the residents prepare and consume the meal. We also help the clients dress appropriately for the weather and accompany them to the busses. The other residents are no woken. They are also assisted with their morning ablutions and we breakfast together with them.

Since different things have to be taken care of every day, the morning's procedure varies. This can include, for example: Shopping, cleaning the rooms, activities and doctor's visits. The residents are involved in preparing the midday meal. After lunch, the residents have a quiet period. During this time, any special events are entered into the documentation system and a shift handover from early to late shift takes place.

At about 2:30 p.m., the clients are again woken and given a snack. The students and workers return one by one to the facility. During the snack, a discussion takes place as to what is going to happen in the afternoon. The clients tell what they would like to do with their leisure time. The residents are again involved in preparing the evening meal and their wishes are taken into account.

When everything is ready, the clients and employees (trainees) partake of the evening meal together. The table is cleared by all. Then evening ablutions are performed. The residents can now occupy themselves with various activities. If these could go on until late, they are told to curtail the activities. The last duty of the day is to make entries in the daily care documents and hand over the shift.

Finsterwalde Elster workshop

Daily routine of a remedial carer

I'm doing my practical training in the Finsterwalde Elster workshop, in the support and activities zone. I start work every day at 8 a.m. and finish at 3:15 p.m., except Fridays, when I finish at 12:30.

When I come into the workshop early, most of the people to be cared for are already there.

I have a disabled person (Marc) entrusted to my care who is only 20 years old. He has had a severe illness called Fahr's Syndrome since he was two. In the meantime it has affected him so severely that he can only sit in a wheelchair and can do almost nothing by himself.

All of our clients eat breakfast at 8:30 a.m. but I start at 8 a.m. because I have to feed my patient. The table is set every morning in my group, and I keep an eye on it to see that it's properly set and that all the cups are in the correct place. Everyone has his own particular place at the table.

Breakfast is served up until about 9:15 a.m. Afterwards I take my patient to the toilet and help him onto the seat. I tell him to press the peeper when he's finished.

In the meantime I go and have a look to see if the table has been cleared away. As soon as I've got my patient back from the toilet, we start our occupational therapy.

In our workshop, we have an activity plan. This tells us what's lined up day for day and what patient is taking part in what activity. The activities themselves start around 9:30 a.m.

For example if my group has owned economics, I'll prepare a salad or something similar together with them. I give the disabled clients something to

cut up. I help Marc, of course, because he no longer has much control over his arm and hand movements. This kind of occupation always goes on till around 10:30 a.m. Then they all have to get dressed because we are going outdoors. Sometimes we have to help dress them.

I go into the dining room with Marc and another client a little early, around 11 a.m., to have our midday meal. In our facility, the disabled people can lie down for a while. If they don't want to, they're given something to do which is not noisy. I usually think of something I can do together with these clients.

The activity plan is used again in the afternoon. Afternoon activities usually start at around 1:15 p.m.

I often take two or three clients (the person I care for is one of them) to the Snoezelen (controlled multisensory stimulation) room, they can relax there. I always play some soothing music and often give them a basal stimulation with the help of a massage ball or something similar.

We have coffee at around 2:30 p.m. and I help some of them get dressed for outdoors at about 3:15 p.m. They're then collected and taken to their own home or to the residential homes.

Daycare integration nurseries

The daily routine of an integration daycare nursery mostly commences at around 8 a.m. The children, who tend

to visit the nursery, are looked after by the early shift.

Breakfast is served from 8 to around 9 a.m. Table manners have to be observed. After all the children have finished, they usually go to the washroom to wash their hands and faces. The time between 9 a.m. and 10:15 a.m. is used for playing in the rooms. During this time, the integration children are sent to, or collected from, their support classes or special activities. If the weather is good, they're sent outside to play at about 10:15 a.m. They're allowed to really let go then but care has to be taken that they don't, among other things, injure themselves. They go to eat their midday meal in different age groups from 11:15 a.m. onwards. Afterwards they're sent to the washrooms again to wash themselves and clean their teeth. Great care is taken that all of the children observe the rules of cleaning teeth. Following this, they're all sent to the toilet. After they've gotten ready, they are sent to bed for a sleep. Mostly, the ritual has to be that the teacher tells them a bedtime story. While they're asleep, the trainees and teachers usually make up decorative materials for the facility or perform other important tasks that would not be possible at any other time. Bedtime ends at 2 p.m. The rooms are tidied up and made ready for a coffee break, which usually lasts to around 3 p.m. Everyone then goes outside. The children who haven't yet been collected by their parents are handed on to the late shift at 3 p.m.

2. Tests for Developmental Diagnosis

The *Frostig development test for visual perception* examines, for example:

- ◆ Eye – hand coordination
- ◆ Figure – ground differentiation
- ◆ Form – constancy perception
- ◆ Position in space perception
- ◆ Spatial relations perception

The *Hamburg – Wechsler intelligence test for Children* examines:

- ◆ Scope of knowledge
- ◆ Power of recall
- ◆ Arithmetic capabilities
- ◆ Vocabulary
- ◆ Perception
- ◆ Understanding and registering of overall social situations
- ◆ Visual – motor coordination
- ◆ Registering of overall relationships
- ◆ Purposefulness
- ◆ Perseverance

A supporting diagnosis checking procedure that is often used is the *P-A-C System according to Guenzburg (P-A-C = Pedagogic Analysis and Curriculum)*. It is one of the few standardized systematic observational systems that allows capture and good presentation of changes. It assumes that in the four development areas of speech, motor functions, social behavior and perception there are capabilities which build on top of one another, and

are acquired one after another. These are observed in everyday group work and entered into a circular diagram. The P-A-C offers, through its various form sheets, the possibility of ascertaining and recording the ability to come to terms with life and the social capabilities of all disabled persons in any age group. The items selected act as building blocks to determine and encourage autonomy and independence from a small child through to an adult. As well as an assessment oriented towards the age of the client, P-A-C forms are especially suitable for the support of severely disabled persons (S/P=P-A-C, S/P-A-C 1 and S/P-A-C 2) and for the older mentally handicapped subgroup.

The **SIVUS method** (Swedish abbreviation of Sozial Individ Via Utveckling Samverkan; in English social-individual through cooperation) was created for people with a cognitive disability to permit their development through joint action. This method can be used both in a workshop for disabled persons as in, for example, a care home.

Other test procedures used in practice are:

- ◆ HKI – Heidelberg Competence Inventory
- ◆ Milestones in Development
- ◆ The Functional Development Diagnosis

After extensive and exact recording of the present stage of development of the

client, an individual **support plan** for the disabled person is created, with the already-mentioned goal of establishing ever-improving personal and structural conditions for integration into, and participation in, the life of society.

(Based on Kornelia Sinner, 'Remedial Teaching Diagnosis', October 2006)

3. Curriculum – remedial carer

The vocational role of future remedial carers demands on one hand core remedial care abilities such as observational and analytic skills, the ability to set up relationships and also the ability to plan, implement and evaluate remedial processes. On the other hand, professionalism and readiness and ability to engage in teamwork, work with specialists, relatives and other carers in accordance with the legal requirements of caring, as well as willingness to be measured on concept justification and quality assurance of the work, in which the development of new fields of activity, including independent management of facilities and services, must be taken into account.

Curricular requirements divide into three areas:

1. Cross-vocation learning area
General knowledge in the discipline is acquired here
 - ◆ German/communication, English, information processing, biology and education on constitutional structures
2. Vocation-related learning area
Professional knowledge in seven subject areas is acquired here
 - ◆ The goal of concentrating on subject areas is:
Support for the acquisition of

knowledge in vocation-related and cross-vocation contexts

Monitoring of the development process towards a considered vocational role as a carer

Support of activity-oriented tuition as well as linking theory to practice

Allowing integration and responsible setup of remedial processes

3. Subject of choice

Participants in the additional German/

Communication and mathematics courses can obtain a technical college entrance qualification

Practical experience is gained by the students in managed remedial care fields of activity such as:

- ◆ Inpatient care
- ◆ Social teaching support facilities for disabled persons
- ◆ Support facilities for disabled persons
- ◆ Outpatient services

The practical phases can be completed on a day or week basis and take up around a third of the complete course time.

The planning and organization of the course is the responsibility of the school concerned. The framework guidelines given to every school allow the knowledge to be imparted by means of internal school goals.

The main goal of training to be a remedial carer is the gaining of comprehensive professional skills. This can be split into vocational

skill, personal skill, social skill and methodology and learning skill.

The educational course is concluded after three years with a written and oral vocational college examination and carrying out of a practical 'suitable procedure'.

4. Occupational possibilities for disabled persons

The possibilities for disabled people to participate in general work and life are still marked by grave limitations, shown in a below-average share of work, an above-average unemployment rate, and a further reduction in the willingness of employers who are required to employ such persons, to do so, expressed by them not, or insufficiently, filling their legally required quotas.

An occupation is, for a disabled person, a major prerequisite to being able to take part in the life of society; for this reason it is particularly important that disabled persons find work. The central task of those services aimed at participation in working life is to empower disabled people to find an occupation that is in line with their capabilities and is as permanent as possible.

There are numerous methods of assistance available to help integrate disabled people into working life. The buildup of legislative and institutional conditions has created a differentiated system of occupational rehabilitation in Germany, with the corresponding duties split between various bodies responsible for costs and supply of services.

Occupational support

The necessary help can be offered here for the obtaining, improvement, retention or reestablishment of an occupation for a disabled person, taking into account his performance, his aptitude and his previous occupation.

Disabled people who already were in employment, should as far as possible keep the previous workplace, or at least the previous job. If this is not possible, then there is a possibility of learning a new occupation; the Federal Office of Employment employees responsible can be helpful here.

Reintegration into the previous occupation is very important because on one hand it makes it easier to get over the consequences of the disability, while on the other hand, the disabled person can use his knowledge and experience to the fullest extent.

Occupational further education

Occupational further education can help in ensuring that a job is retained. It builds on previous occupational knowledge, refreshes know-how, fills any gaps that exist and extends know-how and brings it up to date with current technical, business and organizational information. In addition, further education can help occupational advancement.

Occupational reorientation

This is necessary when the previous occupation can no longer be practiced.

If there is doubt or uncertainty with regards to reorientation, various occupations and workplaces can generally be tried out for two weeks, and longer if needed. Should it prove necessary, a preparatory course on the basics or a course for blind persons or a similar special basic education can precede actual educational measures.

Retraining

Retraining is meant to facilitate the transition to another occupation. A new occupation can be learnt in a business, in a further educational facility or in an occupational support amenity. Retraining is mostly offered for occupations that are recognized as requiring training. It lasts two years and concludes with a Chamber of Commerce examination.

For disabled adults who, due to the type and severity of their disabilities can neither practice their previous occupation or be retrained in a business or general further education facility, there are occupational support amenities.

These are educational facilities which pass on to their clients the necessary occupational knowledge and skills, teach social behavior for the future working life, and generally align the further education and retraining with a form of care tailored to individual needs. The educational offerings include commercial, administrative, industrial and health and social care occupations.

Workshop for disabled persons

Disabled adults, who, due to the type and severity of their disabilities cannot, cannot yet or cannot yet again be employed on the general employment market, find a place in a workshop for disabled persons. These facilities are open to all irrespective of the nature and severity of the disability.

Workshops for disabled persons generally have a threefold zone structure, the various areas building on each other or linking to each other:

Incoming procedure: After admittance, the first four weeks to three months are spent in finding out whether the workshop is a suitable facility for occupational integration and whether employment in the work area or in the general workplace market is possible.

Work training zone: Integration into the work training area lasts two years. During this time, a basic and an upper level course are completed. These courses teach skills for certain work processes and in addition, social- and work-related behavior is fostered and practical living skills taught.

Work zone: This area comprises workplaces that suit the abilities of the disabled persons who use them.

Support and activity zone: Adults with multiple and severe multiple

disabilities who do not, or not yet, fulfill the preconditions for admittance to a workshop for disabled persons can, under certain conditions, be admitted to the support and activity zone. This zone is a facility for both social integration and preparing for occupational rehabilitation. It offers measures to retain and improve skills gained, for example in the areas of speech, practical living and artistic activities, as well as further development of the personality in the social, musical and creative fields.

A minimum amount of economically realizable work must be carried out; however this must be interpreted in a broad and generous fashion to allow people with severe disabilities to work. The workshops must operate on the assumption that all disabled persons in their catchment area can be admitted.

In the Elbe-Elster region, workshops for disabled persons, known here as 'Elster Workshops', are to be found in Herzberg, Bad Liebenwerda, Kraupa and Massen/ Finsterwalde (see map).

As workshops for disabled persons, they must offer a qualified range of work possibilities that takes into account the capabilities of the individual employee while both making demands on them and encouraging them. Workshops for disabled persons have a so-called dual task to fulfill, i.e. working in

such a workshop should on one hand be directed at integrating disabled people into the general employment market, achieve optimum productivity and customer satisfaction, and on the other hand they must ensure optimum encouragement of the capabilities and personality of the disabled person, offering those with severe disabilities suitable employment and care.

These workshops offer a highly differentiated and creative range of work, varying from simple assembly, packing tasks and wiring harness production through to kitchen services, bookbinding work, wood and paper processing, as well as tending of gardens and grounds.

Complex manufactured items are produced in many small manageable steps with differing degrees of difficulty to give work to many. A workshop for disabled people has at least 120 workplaces, work being performed in groups or departments, with one carer looking after every 12 disabled employees in the production area.

Disabled employees work eight hours a day and receive the normal annual vacation of around 35 days.

The workshops must themselves earn the money that they pay to their employees. Depending on the region and the general wage level, disabled employees earn between 50 and 350 Euro.

The workshop pays the social insurance contributions itself.

Workshops for disabled persons face a tough competitive battle, because companies increasingly automate the traditional activities carried out by the workshops and perform these themselves. In addition, cheap foreign providers can undercut the already low prices of the workshops due to their low wages.

Specialized integration services

Some of the severely disabled unemployed people, primarily older long-term unemployment cases who are insufficiently vocationally qualified or those particularly affected due to the type and degree of their disability, can only be found work on the general employment market when specialized integration services are available to help them integrate or re-integrate into working life.

These regional networks of specialized services carry out the following tasks:

- ◆ Advising and supporting severely disabled people and providing them with suitable workplaces
- ◆ Informing and advising employers, creation of workplace analyses that list the capabilities and the work steps demanded
- ◆ Supporting the Federal Employment Office in carrying out its tasks, particularly those of advising

severely disabled persons before they commence employment, in looking for employment, and in how to apply for a job

- ◆ Supporting the vocational training of severely disabled persons, particularly young people with psychic and learning disabilities
- ◆ Supporting severely disabled people at their workplace after they have commenced employment or when they are on practical training for their vocation
- ◆ When transitioning disabled people from a workshop for the disabled or from a special school for mentally handicapped people into employment in the general employment market

Alternative work possibilities

Integration projects

These are legally and economically independent integration companies and businesses on the general employment market that employ severely disabled or psychically ill employees. In these firms, which are often very small, a minimum of 25 and a maximum of 50 out of every 100 employees must be severely disabled. These integration companies offer a statutory agreed wage and permit the person concerned, because of the regular conditions of work, to largely self-determine his own life under his own responsibility.

Financing of the construction, extension, modernization and equipping of these projects, as well as

economic advice for them is done by means of the equalization tax.

Living and working community villages

Both disabled and non-disabled people can live and work in these communities. The range of work encompasses gardening and home economics through to animal husbandry, bakeries, potteries and other. There are also successful module projects such as tea shops, supermarkets, laundries and hotels, in which severely mentally handicapped people carry out the necessary work after extensive training and direction, and for which they receive the statutory agreed wage.

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Deutscher Bildungsrat, Empfehlung der Bildungskommission, 1973, (German Educational Council, Education Commission Recommendations)

Bundesministerium für Arbeit und Soziales, Ratgeber für behinderte Menschen (Adviser for disabled persons). Bonn 2006

Internet Resources

Berufsverband der Heilpädagogen
Michaelkirchstr. 17/18
10179 Berlin
www.heilpaedagogik.de

Bundesvereinigung Lebenshilfe
Für Menschen mit geistiger
Behinderung e. V.
Raiffeisenstraße 18
35043 Marburg
www.lebenshilfe.de

Statistisches Bundesamt
www.destatis.de

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Notes

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www.vitaliscollege.nl

www.linkoping.se/birgitta

www.stevenson.ac.uk

www.oszee.de

www.dundeecoll.ac.uk/?about_us/european_projects.xml