



Comprehensive training programme for informal advisors to parents
of children with disabilities

MODULE I

INTRODUCTION TO SUPPORTING PEOPLE WITH DISABILITIES.

THE ROLE OF AN INFORMAL ADVISOR

2024-1-TR01-KA220-ADU-000250033

**INNOVATIVE SUPPORT AND EDUCATION FOR PARENTS OF CHILDREN
WITH DISABILITIES THROUGH INFORMAL COUNSELLING**

IPAR



Co-funded by the
European Union

Table of contents

1. Introduction
2. Basic information about types of disabilities
 - 2.1. Physical disability
 - 2.2. Intellectual disability
 - 2.3. Visual disability
 - 2.4. Hearing disability
 - 2.5. Autism and autism spectrum disorder (ASD)
 - 2.6. Multiple disabilities and other forms of developmental disorders
3. The importance of early diagnosis and intervention
 - 3.1. Early detection of disability
 - 3.2. Early intervention – definition and objectives
 - 3.3. Consequences of failing to diagnose early
4. Rights of persons with disabilities
 - 4.1. Legal basis
 - 4.2. Right to education
 - 4.3. Right to social support and state assistance
 - 4.4. The right to independent living and participation in social life
5. Personality and competences of an informal counsellor
 - 5.1. Who is an informal counsellor?
 - 5.2. Professional and methodological skills
 - 5.3. Personal competences
 - 5.4. Social and communication competences
 - 5.5. Ethical and reflective attitude
6. Conclusion
7. Bibliography

1. Introduction

1.1. The concept of disability – definitions and contexts

Disability is a complex phenomenon, encompassing biological, psychological, social and cultural dimensions. There are many definitions of this concept in scientific literature, differing in emphasis and in the way they approach the relationship between the individual and the environment. According to the **World Health Organisation (WHO)** definition contained in *the International Classification of Functioning, Disability and Health (ICF, 2001)*, disability is an umbrella term that covers all limitations on activity and participation resulting from the interaction between a person's health condition and environmental factors. In this sense, disability is not solely the result of bodily impairment, but a consequence of the dynamic interaction between an individual's characteristics and the conditions in which they live.

In turn, **the UN Convention on the Rights of Persons with Disabilities (2006)**, ratified by Poland in 2012, defines persons with disabilities as those who "have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". In this definition, the emphasis has shifted from a medical description of deficits to social mechanisms of exclusion, highlighting the importance of the environment and its accessibility.

Disability can therefore be understood in **three complementary contexts**:

- **Medical**, which focuses on the diagnosis and treatment of bodily damage, viewing a person with a disability as a patient requiring therapeutic intervention;
- **Social**, in which disability is the result of environmental maladjustment and lack of accessibility, rather than a characteristic of the person;
- **Cultural**, which recognises disability as part of the diversity of human experience and identity, requiring acceptance and representation in public spaces.

Over the past few decades, we have seen a clear **paradigm shift** in the perception of disability – from **the so-called medical model to the social model**.

In the medical model, a person with a disability was primarily an object of care, therapy and corrective measures. The focus was on functional limitations and ways to compensate for them. The social model, developed in the 1970s under the influence of emancipation movements and non-governmental organisations, assumes that the source of disability is barriers – architectural, communication, legal, social and mental – which prevent people with various limitations from fully participating in social life. In this approach, responsibility for social inclusion shifts from the individual to society and its institutions.

Nowadays, in line with the idea **of social inclusion** and the concept of a "society for all", disability is treated not as a deviation from the norm, but as one of the natural variants of the human condition. The goal of social policy and practice is not so much to rehabilitate the "lack" as to create an environment that enables each person to function according to their potential and aspirations.

1.2. The purpose and importance of supporting people with disabilities

Supporting people with disabilities is one of the cornerstones of modern social systems based on the principles of equality, solidarity and respect for human dignity. This support includes both institutional

measures (e.g. education, social assistance, rehabilitation, supported employment) and informal initiatives carried out by families, local communities, volunteers and informal advisors.

The primary goal of support is **to enable persons with disabilities to be as independent and active in social life as possible**, while respecting their individual needs, limitations and choices. Independence in this context does not mean complete independence from others, but the ability to make decisions, express opinions, fulfil social roles and exercise civil rights in a manner appropriate to the individual's capabilities.

The second key objective is **social integration**, understood as a process of mutual adaptation between individuals and their environment. This means not only providing people with disabilities with support tools and services, but also eliminating architectural, informational and mental barriers that hinder their participation in public life. Integration is not a one-sided process – it requires openness, education and empathy on the part of society as a whole.

The role of the social environment in the process of rehabilitation and inclusion of people with disabilities cannot be overestimated. It is in everyday interactions with family, neighbours, colleagues or the local community that a person with a disability experiences real support or, conversely, exclusion. That is why contemporary concepts of social rehabilitation emphasise the importance of **an individual's natural environment** – the place where they live, learn and work – as a key factor in the development of social skills and a sense of belonging.

In this context, **informal counselling**, which is a form of support provided by people outside the institutional system – family members, friends, volunteers or community leaders – becomes particularly important. An informal advisor does not act as a therapist or official, but as a companion and advocate for the person with a disability. They help them navigate the support system, provide emotional support, facilitate contact with institutions, and often represent their interests in social situations. Their role is **relational and humanistic** – based on empathy, understanding, trust and acceptance.

Informal counselling is therefore an important link between the formal support system and the individual experience of a person with a disability. In the era of transformation towards an inclusive society, where emphasis is placed on the participation and agency of every human being, informal advisors are becoming indispensable partners in building a culture of understanding, openness and mutual respect.

2. Basic information about types of disability

Disability, regardless of its nature and degree, always affects how an individual functions in social, educational and professional environments. Its consequences are not limited to the physical or cognitive sphere – they also extend to the emotional, relational and identity spheres. Therefore, the contemporary approach to describing types of disability requires consideration of both medical and psychosocial aspects.

2.1. Physical disability

Physical (mobility) disability includes any permanent or temporary limitations in motor function resulting from damage to the musculoskeletal system, nervous system or motor organs. It may be the result of congenital defects, diseases (e.g. cerebral palsy, muscular dystrophy, multiple sclerosis, rheumatoid arthritis), injuries, amputations or disorders of the nervous system.

From a functional perspective, this means difficulties in moving around, performing daily self-care activities, maintaining balance or manipulating objects. The scale and nature of the limitations vary – from mild motor difficulties to complete dependence on a wheelchair or carer.

The contemporary approach to people with physical disabilities emphasises the importance **of compensation and adaptation of the environment**. Modern assistive technologies (e.g. electric wheelchairs, exoskeletons, voice control systems) significantly increase independence, while adapting public spaces – by removing architectural barriers – enables fuller participation in social life. Physical rehabilitation and occupational therapy are also important elements of support, contributing not only to maintaining physical fitness, but also to rebuilding a sense of agency and social competence.

2.2. Intellectual disability

Intellectual disability, formerly referred to as mental retardation, is a condition of reduced intellectual and adaptive functioning that manifests itself during the developmental period. According to the American Psychiatric Association's classification (DSM-5), it covers three areas: intellectual functioning (reasoning, learning, problem solving), adaptive functioning (social, communication and practical skills) and age of onset (before the age of 18).

There are four degrees of intellectual disability: mild, moderate, severe and profound. Each of these requires a different approach to education and care. People with mild intellectual disability are often able to function independently, perform professional work and form social relationships with appropriate support. In the case of severe or profound disability, systematic assistance in everyday life and specialist care are essential.

Special education emphasises the importance **of individualised teaching, simplicity of communication, repetition and positive reinforcement**. It is also essential to develop social, self-care and communication skills. Support should be multidimensional, encompassing educational, emotional and therapeutic activities, with the overriding goal of sustaining and developing the person's potential, rather than merely compensating for deficits.

2.3. Visual impairment

Visual impairment includes both **blind** and **partially sighted** people who have a permanent or progressive limitation of visual function that cannot be fully corrected with glasses or contact lenses. Depending on the degree of vision loss, the possibilities for perceiving visual stimuli and compensatory strategies vary.

Vision loss affects how we perceive the world, our spatial orientation and speech development. That is why, when working with people with visual impairments, it is important **to support compensatory processes by developing the senses of touch, hearing and kinesthesia**. Blind people use Braille, audio devices, voice navigation, and digitally accessible materials in education.

Visual impairment often leads to secondary emotional and social difficulties – reduced sense of security, fear of independent movement or isolation. Support should therefore include not only vision rehabilitation, but also **training in independence and spatial orientation**, as well as activities that integrate individuals into their environment. Modern technologies – such as location apps, text and image recognition, and voice assistants – significantly increase the level of independence of people with visual impairments, but at the same time require appropriate educational and technological preparation.

2.4. Hearing impairment

Hearing impairment includes **deaf** and **hard-of-hearing** people who experience limited perception of acoustic stimuli to varying degrees – from partial hearing loss to complete deafness. The causes may be congenital or acquired (e.g. infections, injuries, middle ear diseases, noise, genetic factors).

Hearing loss not only affects the perception of acoustic stimuli, but also has a multidimensional impact on **language development, social communication, education and individual identity**. In the case of children who are deaf from birth, the consequences of not having access to spoken language can manifest themselves in early childhood in the form of developmental delays in speech, understanding abstract concepts and emotional functioning. That is why it is so important to ensure **early diagnosis and auditory intervention**, as well as to enable the child to come into contact with a fully-fledged language system – most often the national sign language.

In **Poland**, this role is fulfilled by **Polish Sign Language (PJM)** – an autonomous language system with its own grammar and syntax, which differs from the Polish language. Similar situations exist in other European countries: **Slovakia** has **Slovenský posunkový jazyk (SPJ)**, which in 1995 was granted the status of an official language of the deaf community and was recognised as part of the country's cultural heritage. Slovakia also pursues an active policy of supporting bilingualism in the education of deaf children – through the development of teaching programmes in sign language alongside Slovak. Despite this, there is still a limited number of certified interpreters and insufficient technological support in smaller towns.

In **Turkey**, the situation is more complex. Although **Turkish Sign Language (TİD)** has a rich tradition and has been officially recognised by the state since 2005, its presence in the education system and public administration remains fragmented. Many schools for deaf people still use the so-called oralist approach, which focuses on learning speech and lip reading, with limited use of sign language. In recent years, however, thanks in part to cooperation with European organisations (e.g. the European Union of the Deaf), a movement for **full communication accessibility** has been developing, including translation in public media, the development of television subtitles and communication support applications. However, Turkey still lacks consistent regulations guaranteeing the accessibility of public services for deaf people throughout the country, especially in rural and eastern regions.

Across Europe, there is a growing emphasis on **a comprehensive approach to hearing impairment**. This means not only investing in technology (hearing aids, cochlear implants, FM systems, induction loops), but also recognising **deafness as a cultural and identity phenomenon**, rather than solely a medical one. The contemporary biopsychosocial approach promotes the integration of two paradigms: **rehabilitation**, which focuses on improving hearing function, and **culture**, which emphasises the right to use sign language and participate in *Deaf culture*.

Nowadays, there is an increasing emphasis on **communication accessibility** – sign language interpretation in the media, subtitles in video materials, accessible helplines and assistance services. The education of people with hearing impairments should be based on visual methods that engage sight, gesture and movement, and the learning process should promote the development of social, emotional and cultural skills.

2.5. Autism and autism spectrum disorder (ASD)

The autism spectrum (Autism Spectrum Disorder – ASD) encompasses a group of neurodevelopmental disorders characterised by difficulties in social communication, restricted patterns of behaviour, and a specific way of perceiving and processing sensory stimuli. According to the latest diagnostic classifications (DSM-5, ICD-11), autism is treated as a continuum of functioning rather than a uniform disease entity.

People on the autism spectrum often exhibit sensory hypersensitivity or hyposensitivity, a need for predictability and repetitive rituals, and difficulties in understanding other people's intentions and emotions. At the same time, many of them demonstrate **above-average abilities in specific areas**, such as mathematics, music, data analysis, or visual information processing.

Supporting people with ASD requires an individual approach that takes into account their sensory profile, learning pace and preferred method of communication. Various methods are used, including **TEACCH (Treatment and Education of Autistic and related Communication-handicapped Children)**, **ABA (Applied Behaviour Analysis)** and the **SCERTS model**, which emphasise the development of communication, emotional self-regulation and social skills.

It is also extremely important **to educate the public about the acceptance of neuroatypicality** – moving away from perceiving autism as a deficit in favour of neurological diversity. This allows people on the spectrum to function in an environment that supports their potential rather than limiting their differences.

2.6. Multiple disabilities and other developmental disorders

Multiple disabilities occur when two or more types of disabilities coexist in one person, e.g. intellectual and physical, hearing and visual, or autism and intellectual disability. The complex nature of these disorders means that educational, therapeutic and care needs are much more complicated, and the support process requires **the cooperation of an interdisciplinary team of specialists**: special educators, speech therapists, sensory integration therapists, psychologists and doctors.

In the case of people with multiple disabilities, the priority is **to maintain vital functions, develop alternative and augmentative communication (AAC)** and ensure the highest possible quality of life. The family environment also plays a key role and needs comprehensive support – psychological, informational and material.

Understanding the diversity of disabilities is the basis for effective and empathetic support. Each disability requires a slightly different approach, but they all share a common goal – **to ensure that people with disabilities can participate fully in society**. Contemporary pedagogical and social concepts emphasise that disability does not define a person, but is one aspect of their functioning. It is the responsibility of society to create conditions that allow every person to realise their rights, potential and needs in a spirit of equality and respect.

3. The importance of early diagnosis and intervention

Early diagnosis and appropriately selected support measures are a key element of the system of assistance for persons with disabilities. Contemporary research in the fields of developmental neuropsychology, special education and occupational therapy clearly indicates that **early childhood is the period of greatest plasticity of the nervous system and most effective learning**. For this reason, proper diagnosis and intervention in the first years of life can significantly influence a child's further development and cognitive, emotional and social functioning.

3.1. Early detection of disabilities

The diagnosis process in the area of disability is multi-stage and interdisciplinary. It includes **clinical and pedagogical observation** as well as **psychological, speech therapy, medical and neurophysiological examinations**. The first people to notice worrying developmental symptoms are usually parents or carers. Their observations, concerning, for example, delays in speech development,

motor skills, eye contact or emotional responses, are a valuable starting point for further specialist diagnosis.

Paediatricians, community midwives, nursery school teachers and psychologists in psychological and pedagogical counselling centres also play a key role in the early detection system. Their task is not only to initially identify difficulties, but also to refer families to diagnostic centres. In this context, it is extremely important to raise public awareness of the early signs of disability and to foster openness towards the diagnostic process.

Modern education and healthcare systems assume **preventive screening tests** carried out at specific stages of a child's development – e.g. at 2, 4 and 6 years of age. Their aim is to detect even subtle deviations from the developmental norm. Early diagnosis is not about labelling a child, but rather a **tool for precisely planning support** that allows them to maximise their potential.

3.2. Early intervention – definition and objectives

The concept of **early intervention** refers to integrated therapeutic, educational and upbringing measures taken in relation to children with developmental disorders and their families from birth to around the age of 7. The aim of these measures is not only to improve impaired functions, but also to **prevent further developmental delays and to support parents' competence in caring for and raising their child**.

Early intervention takes various forms – from individual sessions with therapists (e.g. speech therapists, physiotherapists, psychologists, special educators) to comprehensive community programmes involving the family, school and local institutions. Its effectiveness stems from a holistic approach – covering not only the child, but also their entire environment.

The basic principles of early intervention are:

- **individualisation** – adapting methods and goals to the child's abilities and pace of development;
- **comprehensiveness** – combining various forms of therapeutic and educational interventions;
- **continuity** – systematic action and monitoring of progress;
- **family involvement** – active participation of parents in the therapy process.

In practice, this means that intervention cannot be limited to specialists working with the child, but must also include **educating parents**, strengthening their parenting skills, and building emotional bonds and trust in the support system.

Empirical research confirms that children who have received early intervention **achieve higher levels of cognitive, emotional and social functioning** compared to children who only received help at school age. However, the effectiveness of these measures depends on the availability of specialists, cross-sector cooperation and the awareness of parents and teachers.

3.3. Consequences of not getting an early diagnosis

The lack of early diagnosis or its delay often leads to **the deepening of developmental difficulties**, which over time affect other areas of the child's functioning. Undiagnosed cognitive, sensory or emotional deficits can cause secondary behavioural disorders, educational and social difficulties, and, as a consequence, exclusion from peer groups and low self-esteem.

From a systemic perspective, delayed intervention also generates **higher social and economic costs** associated with the need to introduce long-term compensatory and care measures at a later stage. For this reason, contemporary education and health policies are based on the principle of **'the earlier, the better'**, which is the foundation for effective social and professional rehabilitation in adult life.

It is worth emphasising that early diagnosis is not only a medical issue, but also **an ethical and social** one. It enables families to make informed decisions about further care, therapy and education, and provides children with access to equal development opportunities. Delays in diagnosing developmental problems are often due to a lack of knowledge, taboos or parents' fear of stigmatisation. Therefore, an important element of the support system is **social education and psychoprophylaxis**, which break down stereotypes and promote an attitude of early response to worrying symptoms.

3.4. Cooperation between specialists and the family environment

The effectiveness of early diagnosis and intervention largely depends on the quality of cooperation between the various links in the support system: health services, education, social assistance and non-governmental organisations. It is extremely important to create **interdisciplinary teams** that combine medical, psychological and pedagogical competences.

The family of a child with a disability should be treated as **an equal partner** in the diagnostic and therapeutic process. It is the parents who are the most important source of information about the child's behaviour, progress, difficulties and emotions. Involving parents in the therapy planning process increases the effectiveness of the measures taken, reduces their sense of helplessness and strengthens their agency.

It is worth emphasising that early intervention should also include **emotional support for the family** – psychological help, support groups, counselling. The early stages of diagnosis are often a time of severe stress, uncertainty, and a sense of loss for parents. Properly conducted psychological assistance allows them to gradually accept the situation, understand the child's needs, and become involved in their development.

3.5. The importance of informal counselling in the early support process

Informal counsellors – close relatives, volunteers, local community leaders – can play an extremely important role in the process of early support for children and their families. It is often they who, thanks to their daily contact, notice the first symptoms of developmental difficulties and encourage parents to consult specialists. Their empathetic presence, emotional support and assistance in dealing with institutions can significantly reduce parents' stress levels and make it easier for them to take action.

The inclusion of informal counselling in the early intervention system broadens its scope and makes it more **humanistic, accessible and understandable** to families. Informal counsellors act as a link between specialists and the child's environment, contributing to the building **of a community that supports development** – based on trust, empathy and shared responsibility.

Summary

The importance of early diagnosis and intervention cannot be overestimated – it is the foundation for effective assistance, integration and development of people with disabilities. Early detection of developmental difficulties not only minimises the effects of deficits, but above all **prevents secondary psychological and social consequences**. Early intervention, carried out in a spirit of cooperation between specialists, the family and the community, becomes the first step towards inclusion, equality and full participation in social life.

4. Rights of persons with disabilities

Contemporary democratic societies are based on the principles of equality, dignity and social justice. One of their fundamental obligations is to guarantee persons with disabilities the same rights and opportunities to participate in social life as all other citizens. The right to an independent, dignified life, to education, work and participation in culture is not a privilege – it is **a fundamental human right**. In this context, the law has not only a regulatory function, but also **an emancipatory and protective** one, providing persons with disabilities with the tools to assert their agency and combat discrimination.

4.1. Legal basis

The rights of persons with disabilities in Europe

Contemporary democratic societies are based on the values of equality, freedom and social justice, which form the foundation for the creation of human rights protection systems. In this context, the rights of persons with disabilities are not a separate category of privileges, but an integral part of the catalogue of human rights. Their essence is to ensure that every person, regardless of their level of ability, has the opportunity to participate fully in social, educational, professional and cultural life.

The law has a dual function here: regulatory, organising relations between individuals and public institutions, and emancipatory, enabling persons with disabilities to use legal tools to enforce their rights, combat discrimination and strengthen their agency in social life.

International legal basis and its significance

The most important international document on the protection of the rights of persons with disabilities is the United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006 and in force since 2008. The Convention introduced a fundamental paradigm shift: from a medical model that views disability as an individual problem to a social model that emphasises the importance of environmental, social and institutional barriers as sources of exclusion.

The preamble to the Convention states that disability is the result of interactions between persons with long-term limitations and attitudinal, environmental and communication barriers that prevent them from fully participating in society. The States Parties have committed themselves to ensuring equal opportunities, access to education, employment and full participation in culture and public life for persons with disabilities.

In Europe, almost all countries have ratified the CRPD, committing themselves to implementing its provisions in national law. However, this process is proceeding at different speeds and with varying degrees of effectiveness.

The situation in Poland

In Poland, the Convention was ratified in 2012, which initiated the process of harmonising national legislation with its provisions. The most important legal acts in this area are:

- The Act on Vocational and Social Rehabilitation and Employment of Persons with Disabilities (1997), which regulates issues of vocational activation, sheltered employment and financial support,
- The Charter of Rights of Persons with Disabilities (1997) – a declarative act that forms the basis for equality policy,
- The Education Law (2016), which guarantees the right to inclusive education and the adaptation of the school environment to the needs of students with disabilities.

The Polish system is also distinguished by the functioning of the State Fund for Rehabilitation of Disabled Persons (PFRON), which plays a key financial and operational role in removing barriers, supporting employment, subsidising rehabilitation stays and the activities of non-governmental organisations.

European context – diversity of models and practices

In European Union countries, it is becoming standard practice to implement the principle of "full participation and equal opportunities" through accessibility policies, educational integration and support for employment in the open labour market. The strategic directions are set out in the European Disability Strategy 2021–2030, adopted by the European Commission, whose overarching goal is to create a "Union of equality" – a space where people with disabilities can enjoy all their civil rights on an equal footing with others.

The strategy identifies three pillars of action:

- Fundamental rights – protection against discrimination and violence,
- Independent living and autonomy – development of services supporting independence,
- Equal opportunities in employment and education – through the removal of infrastructure and communication barriers.

In practice, the implementation of these principles varies depending on the social and political conditions of individual countries.

Slovakia

In Slovakia, the protection of the rights of persons with disabilities is guaranteed by the Constitution (Articles 12 and 38 of the Constitution of the Slovak Republic) and developed in sectoral laws, including the Social Services Act (2008) and the Education Act (2008). Slovakia ratified the UN Convention in 2010 and is taking steps to fully implement the model of social and educational inclusion.

An important element of the Slovak system is the National Programme for the Development of Persons with Disabilities, which focuses on equal opportunities in employment, support for families and accessibility of public spaces. In recent years, Slovakia has invested significant EU funds in the modernisation of schools and the introduction of technologies to support the education of students with disabilities.

However, one of the challenges remains regional disparities in access to services and a limited number of specialists (psychologists, therapists, assistants). Nevertheless, compared to other Central and Eastern European countries, Slovakia is recognised as an example of a country that is consistently building a systemic model of support based on human rights.

Turkey

In Turkey, issues relating to the rights of persons with disabilities are regulated by the Persons with Disabilities Act (2005), and the country ratified the UN Convention in 2009. Although it has formally adopted its principles, in practice the implementation process varies from region to region and is heavily dependent on the availability of resources.

In recent years, Turkey has adopted a number of executive acts concerning the accessibility of public spaces, transport, inclusive education and sheltered employment. The government is running public awareness campaigns under the slogan Engelsiz Türkiye ('Barrier-free Turkey'), and large cities such as

Ankara, Istanbul and Izmir have introduced urban systems to facilitate the mobility of persons with disabilities.

However, in practice, serious difficulties remain, particularly in the areas of inclusive education and access to the labour market. Research by the Turkish Ministry of Family and Social Policy indicates that employment rates for persons with disabilities remain below 30 per cent, and are significantly lower in rural areas.

Non-governmental organisations such as Türkiye Sakatlar Derneği play an important role in monitoring compliance with rights and promoting social awareness in the spirit of the UN Convention, but their activities are often limited by a lack of stable funding and a highly centralised administration.

Europe as an area of common standards and diverse practices

On a European scale, there is a clear trend towards convergence of legal systems towards a unified model of protection of the rights of persons with disabilities. The common denominator is the recognition that disability is not a characteristic of the individual, but the result of a lack of accessibility and environmental barriers.

At the same time, differences between countries such as Slovakia and Turkey show that the mere adoption of international legal acts does not guarantee full inclusion. Implementation requires sustained investment in education, changes in social attitudes, staff training and effective law enforcement.

4.2. The right to education

Education is one of the fundamental pillars of social integration. It provides opportunities for developing skills, independence in life, and participation in professional and public life. In accordance with Article 24 of the UN Convention on the Rights of Persons with Disabilities, States Parties are obliged to ensure **an inclusive education system at all levels** that takes into account the diversity of students and their individual needs.

In the Polish education system, the right to education is implemented through:

- the possibility of attending **mainstream schools**, with appropriate organisational and teaching adjustments,
- the creation of **inclusive schools and classes** where students with disabilities learn alongside their able-bodied peers,
- and the existence **of special schools** – for pupils requiring intensive therapeutic and rehabilitation support.

The key educational document is **the decision on the need for special education**, issued by a psychological and pedagogical counselling centre, which specifies the forms and scope of support necessary for a given pupil. In practice, this means adapting the curriculum, teaching methods and pace of work, as well as providing specialist assistance – a support teacher, special educator, speech therapist or psychologist.

In the concept of inclusive education, educating people with disabilities is not about adapting them to school, but about **adapting the school to the student**. It is the school's responsibility to create conditions that enable every child to develop to the best of their ability. Education understood in this way not only educates, but also **teaches tolerance, empathy and social responsibility**.

4.3. The right to social support and state assistance

As the guarantor of equality among citizens, the state is obliged to provide persons with disabilities with an appropriate system **of benefits, services and social support instruments**. This includes both financial and non-financial assistance, and its aim is to enable persons with disabilities to live with dignity, be professionally active and integrate into society.

The social support system in Poland includes, among others:

- **cash benefits** – permanent allowances, care allowances, care benefits for carers of persons with disabilities,
- **PFRON targeted programmes** – including "Active Local Government", "Good Start", "Independence – Activity – Mobility",
- **care services and specialist care services** provided at the place of residence,
- **personal assistance system** – enabling persons with disabilities to function independently and participate in social life,
- as well as **housing and employment programmes** that support independence and activation.

In accordance with the principles of the UN Convention, state support cannot be solely protective or charitable in nature – it should lead to **the strengthening of self-determination and civic participation**. This means moving away from a passive (benefit-based) model of assistance towards a model **of active social inclusion**, in which persons with disabilities are co-creators of the support process, not just its beneficiaries.

4.4. The right to independent living and participation in society

The right to independent living is one of the key human rights, confirmed in Article 19 of the UN Convention. It assumes that every person with a disability has the right **to choose their place of residence, lifestyle and decide on their daily functioning**. In practice, this means that the state has an obligation to create conditions that enable persons with disabilities to participate fully in society without having to give up their autonomy.

The implementation of this right requires, among other things:

- accessibility of public spaces (buildings, means of transport, communication infrastructure),
- accessibility of information and digital technologies (websites, applications, official documents),
- access to culture, sport, education and the labour market,
- and counteracting discrimination in all areas of public life.

In recent years, **the social model of independent living**, based on the idea of empowerment and personal assistance, has played an important role in the implementation of this right. In this approach, a person with a disability is not a passive recipient of services, but **an active participant in community life**, making decisions about themselves, their needs and how to meet them.

4.5. The right to work and professional activation

The right to work is not only a prerequisite for economic independence, but also **a factor in social integration, personal development and self-esteem**.

In accordance with Article 27 of the UN Convention, states are obliged to ensure equal access to employment in the open labour market for persons with disabilities, including through:

- adapting workplaces,
- supporting supported employment,
- counteracting discrimination in the recruitment process,
- and developing a system of vocational training and retraining.

In Poland, these activities are carried out, among others, by **employment offices, PFRON (Polish Fund for Rehabilitation of Disabled Persons) and non-governmental organisations** that run programmes for professional activation, counselling and support for employers. **Sheltered workshops and social cooperatives**, which provide employment opportunities for people requiring special working conditions, are also an important form of support.

However, a modern approach to the employment of persons with disabilities assumes that the goal is not to create "separate" jobs, but rather **equal participation in the open labour market**. In this context, a change in social attitudes is crucial – moving away from stereotypes and prejudices in favour of perceiving people with disabilities as valuable, competent employees.

The system of rights for persons with disabilities creates a coherent structure aimed at ensuring that every citizen has the opportunity to participate fully in social life. However, its effectiveness depends not only on statutory provisions, but above all on **the actual implementation of the principles of equality, accessibility and participation** in the everyday practice of public institutions and local communities.

The law is a tool, but its real significance is only realised when society adopts an inclusive attitude, respecting diversity and ready to share responsibility for the common good. In this sense, protecting the rights of persons with disabilities is not only the duty of the state, but also **a measure of the moral and humanistic maturity of the community**.

5. Personality and competences of an informal advisor

Contemporary support systems for persons with disabilities are based not only on institutional structures, but also on the potential and involvement of local communities. In this context, **informal advisors** play an extremely important role – people who do not have formal professional qualifications in the field of social assistance, but whose attitude, empathy and life experience bring real value to the support process.

An informal advisor is often the link between the institutional world and the everyday life of a person with a disability. It is a role that requires sensitivity, responsibility and emotional maturity, as well as specific interpersonal and organisational skills.

5.1. Who is an informal advisor?

An informal advisor is a person who provides emotional, informational or practical support to a person with a disability without acting as a social worker, psychologist or therapist. They may be a family member, neighbour, friend, volunteer, community leader or person involved in non-governmental organisations.

Their help is **voluntary, relational and personalised**, which distinguishes it from institutional support. They operate not on the basis of regulations, but on the basis of trust, empathy and interpersonal relationships.

The role of an informal advisor is not to replace professionals, but to **supplement the support system** with a human and emotional element. Thanks to daily contact with a person with a disability, the advisor is often the first to notice their needs, mood swings, relationship difficulties or problems with functioning in their environment. They can be a source of stability and a sense of security for the person.

The literature on the subject emphasises that informal advisors fulfil several roles simultaneously:

- **an informational role** – providing knowledge about support options, procedures and institutions;
- **an emotional role** – they provide presence, understanding and acceptance;
- **mediation role** – assists in communication with authorities, doctors, schools, or the workplace;
- **advocate** – represents the interests of persons with disabilities in situations where they are unable to do so themselves.

5.2. Professional and methodological skills

Although an informal advisor is not a professional in the legal sense, their activities should be based on basic methodological and organisational skills, which determine the effectiveness of the support provided.

Firstly, **basic knowledge about types of disabilities** – their specific characteristics, limitations, needs and development opportunities – is essential. This enables the advisor to understand the situation of the person they are working with and avoid misinterpreting their behaviour.

Secondly, it is important **to be familiar with the social support system and assistance institutions**. The counsellor should know where to refer a person with a disability if they need to obtain a certificate, financial benefits, rehabilitation or legal assistance. In this context, it is important to be able to explain complex official procedures in a language that is understandable to the recipient.

Another competence is **planning and coordinating support activities** – e.g. helping to organise medical appointments, therapy sessions, transport or social activities. An informal advisor often acts as an 'organiser of everyday life', helping a person with a disability to maintain their rhythm of life and stay in touch with their environment.

Finally, the advisor should know **the basic principles of interpersonal communication**, active listening and conflict resolution. This enables them to provide effective support without infringing on the autonomy of the person being supported, and to build a relationship based on trust and mutual respect.

5.3. Personal competences

The personality of an informal counsellor is of great importance for the quality of support. Key qualities include **empathy, patience, responsibility, ethical sensitivity and emotional resilience**. Informal counsellors often encounter suffering, frustration, anxiety and helplessness in other people. The ability to maintain emotional balance, without falling into cold indifference, is essential for maintaining a lasting helping relationship.

Authenticity is also important – an attitude of sincerity, openness and consistency between words and actions. A support person must inspire trust, which is only possible when their intentions are clear and their actions consistent.

The sense of purpose and mission, which allows informal counsellors to remain motivated despite difficulties and limited results, cannot be overestimated. Helping others often does not bring immediate results and requires patience and perseverance.

The literature on helping relationships emphasises that in order to effectively support others, counsellors must also **take care of their own mental resources** – using support groups, supervision, rest and reflection on their own emotions. Helping is a two-way process that can lead to burnout if it is not accompanied by self-awareness and self-care.

5.4. Social and communication skills

The relationship between an informal advisor and a person with a disability is based on trust, cooperation and partnership. That is why **social and communication skills** play a key role.

The advisor should be able to **listen actively**, understand the needs, emotions and motivations of the other person. Active listening is not only about receiving information, but also about responding empathically, confirming understanding and searching for solutions together.

Another skill is **barrier-free communication** – adapting language, tone and manner of communication to the recipient's abilities. In the case of people with intellectual or sensory disabilities, this means using simple, clear messages, alternative communication (AAC) or supportive gestures.

An informal advisor should also be able to **build relationships based on mutual respect**, without any domination or dependence. This means recognising the right of the person being supported to make their own decisions, even if they do not always match the advisor's expectations. Another important social skill is **cooperation with other participants in the support system** – family, specialists, representatives of public institutions. As an informal advisor is often a "liaison" between these environments, they facilitate the flow of information, coordination of activities and elimination of misunderstandings.

5.5. Ethical and reflective attitude

Ethics in the work of an informal advisor are just as important as in the work of professionals. The basic principle is to **respect the dignity and autonomy of the person with a disability**. Support should be offered in such a way as to empower the person rather than make them dependent on help.

The counsellor should be guided by the principle of **discretion and privacy protection**. Information obtained in the course of the counselling relationship is confidential and may only be disclosed with the consent of the person concerned.

An important element of ethics is also **avoiding a paternalistic attitude**, i.e. the belief that the counsellor "knows better" what is good for the person being supported. Such an attitude, even if it stems from good intentions, can lead to a reduction in autonomy and reinforce dependence.

An informal counsellor should practise **reflectiveness** – the ability to analyse their own actions, emotions and motivations. Reflectiveness allows them to recognise borderline situations in which help can turn into overprotectiveness, and teaches humility in the face of the complexity of human experiences.

5.6. Informal counsellor in an inclusive society

In an era of social change and growing civic awareness, informal advisors are becoming an important part of an inclusive society. Their activities contribute to building **social capital** based on mutual trust, solidarity and empathy.

In practice, these advisors act as **facilitators of social relations**, inspiring others to take action on behalf of people with disabilities and promoting the ideas of equality and integration. Their work has not only an individual dimension, but also a community dimension – it shapes attitudes, changes language and influences social culture.

In this way, informal advisors contribute to the implementation of the basic premise of the UN Convention – that society becomes complete only when no one is excluded from it.

An informal counsellor is not a profession, but **a social and ethical vocation**. Their strength lies not in structures and regulations, but in relationships based on empathy, authenticity and respect. In a society that is moving towards integration and equality, the role of an informal advisor is becoming increasingly important. It is the advisor who fills the space between the institution and the individual, between the system and emotion. Their attitude reminds us that support does not begin with regulations, but with **a person who sees another person**.

Conclusion

Contemporary concepts of support for people with disabilities are based on a paradigm of multidimensional and interdisciplinary interaction, which takes into account not only the individual's health, but also their potential, needs, social context and environmental barriers. Disability is no longer understood solely as a biological deficit, but as a social and relational phenomenon resulting from the interaction between a person and their environment. This model, referred to as biopsychosocial, now forms the basis of both international classifications (ICF – International Classification of Functioning, Disability and Health, WHO 2001) and European Union public policies.

A multifaceted approach means combining medical, psychological, educational, social and legal measures, while respecting the individual resources and aspirations of persons with disabilities. In practice, this means cooperation between specialists: psychologists, therapists, social workers, educators, doctors, but also representatives of local government institutions and non-governmental organisations.

It is the comprehensive nature of support – rather than individual interventions – that enables the achievement of results in the form of real integration and improved quality of life for persons with disabilities.

In this context, every form of assistance should take into account three equivalent dimensions:

- functional – enabling the performance of everyday activities and independence,
- social – supporting relationships, communication and participation in the community,
- existential – strengthening the sense of meaning, identity and agency.

Thanks to this, support ceases to be an act of charity and becomes a partnership process in which the person with a disability is a co-author of their own life and development.

Among the entities participating in the support system, a special position is held by the informal advisor – a person who is not a professional therapist or employee of a support institution, but plays a key role as an intermediary, interpreter and companion in the daily functioning of a person with a disability. An informal advisor can be a family member, neighbour, local community leader, volunteer or representative of a non-governmental organisation. Their involvement is social and relational in nature, based on empathy, a willingness to cooperate and a sense of responsibility for the common good.

The role of an informal advisor is not limited to helping solve practical problems. It includes supporting autonomy, strengthening competences and building communication bridges between a person with a disability and their environment. Such an advisor provides support not only in everyday decisions, but also in the process of becoming independent, navigating the legal system, and dealing with institutions.

In social terms, informal advisors are an important link in an inclusive society – a space where diversity is not an obstacle but an asset. Thanks to their activities, it is possible to overcome attitudinal and communication barriers, which often prove to be more severe than architectural barriers.

Their role is particularly important in small local communities, where it is precisely the networks of neighbourly and community relations that determine the real level of integration.

An informal advisor does not replace institutions, but complements their activities through a relationship based on trust, closeness and genuine understanding. In this way, they support not only the person with a disability, but also their family, contributing to the building of social capital – the fundamental resource of a modern community.

A modern support system for people with disabilities cannot function in isolation. Its effectiveness depends on continuous social education, the professionalisation of informal advisors and the development of cooperation networks between different sectors – education, health, social assistance, local governments and non-governmental organisations.

It is in the local environment that everyday living conditions, relationships and attitudes towards disability are shaped. Local institutions, schools, cultural centres, parishes, senior clubs and rural housewives' clubs can create micro-support systems that have a real impact on social inclusion.

Education in accessibility, communication and diversity plays a key role, both among informal advisors and more broadly – in the entire community. The continuous improvement of interpersonal and communication skills, empathy, the ability to recognise needs and respond to them appropriately is becoming part of modern civic capital.

European experience shows that where investment is made in training local leaders and volunteers, the level of integration increases and people with disabilities are more likely to engage in professional and social activities.

Cooperation between the public, social and private sectors creates a network in which assistance is not ad hoc, but continuous and consistent. Informal advisors become links between institutions and people, putting into practice the ideas of solidarity, understanding and shared responsibility.

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Test questions

Question 1.

According to the UN Convention on the Rights of Persons with Disabilities, the source of disability is:

- A. solely the impairment of an individual's body
- B. the interaction between an individual's limitations and social and environmental barriers
- C. lack of access to treatment and rehabilitation

Correct answer: B

Question 2.

Which of the following statements best characterises **the social model of disability**?

- A. It focuses on the diagnosis and treatment of an individual's deficits.
- B. It views a person with a disability as a patient requiring medical intervention.
- C. It emphasises the importance of environmental and social barriers as causes of exclusion.

Correct answer: C

Question 3.

The primary goal of early intervention is:

- A. pharmacological treatment of developmental disorders
- B. supporting the child's development and the competence of their family at the earliest possible stage of life
- C. classifying children for appropriate forms of special education

Correct answer: B

Question 4.

The principle of inclusive education means that:

- A. the school should adapt to the individual needs of the pupil
- B. pupils with disabilities should only attend special schools
- C. pupils with disabilities should follow a separate curriculum

Correct answer: A

Question 5.

An informal counsellor should primarily:

- A. make decisions on behalf of the person with a disability
- B. provide emotional and informational support, respecting their autonomy
- C. perform the duties of a professional social worker

Correct answer: B



Funded by the European Union. Views and opinions expressed are, however, those of the author(s) only and do not necessarily reflect those of the European Union or the European Education and Culture Executive Agency (EACEA). Neither the European Union nor EACEA can be held responsible for them.