Submission to the

Senate Employment, Workplace Relations & Education References Committee

Inquiry into the education of students with disabilities

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INTRODUCTION

Scope of this submission

The writer draws on personal experience over 10 years as Manager, Disability Liaison Office, Monash University (including visits to 20 similar university programs in Canada and the USA), Regional Disability Liaison Officer for Victoria and Director, National Clearinghouse on Education and Training for people with disabilities (NCET) project. Observations and suggestions made herein will be limited to the higher education sector.

Groups responsible for the quality of disability services in higher education.

It is often implied that Disability Liaison Officers (DLOs) alone are responsible for the quality of disability services provided in higher education. However, high quality services can only be delivered if relevant professional groups are aware of their responsibilities, trained adequately and committed to such delivery. These groups include:

- **Chancellor and all other senior administrators** eg. University Council, Vice-Chancellor, DVCs, PVCs and Deans all of whom are responsible for the development and maintenance of appropriate attitudes/ policies/ budgets in relation to services for students with disabilities.
- **Officers of the Commonwealth Department** of Education, Science and Training (DEST – formerly DETYA and DEET) who set policies, facilitate funding, evaluate reports under the Higher Education Equity Program (HEEP), engage in profile visits and otherwise liaise with universities regularly.
- **Course designers**/developers who must be clear about the objectives of any course of study and precisely what are the core/ essential functions to be assessed in relation to successful completion. They must be aware of how to appropriately accommodate the disabilities of students so as preserve equity for all students.
- **Marketing staff** involved in the promotion of courses who must be conscious of the use of different media to ensure that students with different disabilities gain equal access to information.
- **Administrative staff** involved in handling application/ selection/ enrolment/ academic assessment (eg. examinations or assignments), results publication, award ceremony processes plus health (ie. regarding students with medical illnesses), security (ie. in relation to students with psychiatric illnesses), housing, financial support and other such student services.
- **Teaching staff** who must learn to be inclusive by acquiring greater skills in the delivery of universally accessible information.
- **Learning support staff** eg. tutors, librarians, laboratory managers who must also acquire greater skills in facilitating the delivery of universally accessible information.
- **Assessors/examiners** who must understand fully the process of performance assessment including the construction of valid examination papers and the conduct of bias-free marking.

- **Medical practitioners** and other appropriate professionals who assess and document the nature and severity of a student's impairment or chronic illness (medical or mental/psychiatric) and recommend accommodations to ensure the student has equal access[1] to educational services.
- **The student body** (ie. all other students including classmates, student unions, clubs and societies) should be aware of the needs of students with disabilities in general, understand the legislation and support the provision of reasonable accommodations – rather than seeing accommodations as an advantage for students who have to manage a disability as well as their studies.
- **Disability Liaison Officers** act on behalf of their employing university to assist in identifying students' disabilities and ensuring that appropriate/reasonable accommodations are available.
- **Students with disabilities** themselves should be actively involved in ensuring that appropriate services are available and provided as required.

Without the committed involvement of people from each of these groups, the provision of disability services in higher education becomes a political and economic minefield in which DLOs frequently find themselves isolated in no-man's land.

The role of Disability Liaison Officers in Higher Education

Disability Liaison Officers (DLOs) have very broad roles:

- **Appraising** 'disabilities': understanding impairments and chronic illnesses so as to be able to evaluate each students' limitations in relation to functions required for participation in the course/s in which they are enrolled;
- **Assessing** requirements: confirming documentation and collating information about students' requirements for disability-related services, accommodations, adjustments, assistive technologies and facilities on campus and in course design, teaching, learning support and assessment methods;
- **Making recommendations**: advising teaching/training and administrative staff regarding disability-related services, accommodations, adjustments, assistive technologies and facilities that should be made available to individual students under institution policy and relevant legislation;
- **Delivering services**: providing some required learning access services eg. the induction/ orientation/ training/ co-ordination or management of disability support workers such as notetakers and Auslan sign interpreters;
- **Negotiating**: arranging for delivery of support services by other teaching/ technical departments and generic students services;
- **Advising** teaching/academic/technical and administrative staff about, and/or providing training in the use of, appropriate assistive technologies;
- **Researching, purchasing/operating** assistive technologies such as equipment (eg. brailler, CCTV, scooter) and computer software (eg. Zoomtext, Jaws).
- **Planning** induction/development programs and preparing budgets;

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[1] It is important to note that disability services are designed to ensure that students with disabilities have reasonable access to education services (enrolment, teaching, learning support, academic assessment etc) but not, as many appear to believe, to ensure students' success.

- **Reporting/accounting** to management and groups on the achievement of goals and the use of resources;
- **Training** technical, administrative and professional groups within the institution in understanding the impact of impairments and chronic illnesses on participation in tertiary education and training and universal/inclusive teaching/training and administrative practices;
- **Balancing** (and being seen to balance) the rights of individual students with the interests of the institution.
- **Engaging with** community education and outreach programs for secondary schools, families and prospective students with disabilities;
- **Supervising** staff and/or reporting regularly to superiors;
- **Sourcing** funds and other resources and preparing submissions /applications
- **Initiating** the (further) development of institutional policies & procedures
- **Monitoring, reviewing and evaluating** policies, programs and procedures;
- **Supporting** the work of the institution's Disability Committee (however named).

TERMS OF REFERENCE

A: CURRENT POLICIES AND PROGRAMS …

Policies and programs generally

The majority of Commonwealth and Victorian/State policies for students with disabilities in place at the moment are almost 10 years old and out of step with developments in other parts of the world.

Many policies still in place in Victoria are also in need of review. Some appear to discriminate against students with diagnosed Learning Disabilities (LD) and Attention Deficit and Hyperactivity Disorder (ADHD).

There is enormous inconsistency between policies and programs developed by the Commonwealth and States/Territories and between the States/Territories themselves. This situation causes frustration and confusion – especially for people with disabilities.

Suggestions for consideration by the Committee:

[1] DEST to establish a national study to review and make recommendations for improving the consistency and viability of Commonwealth and State/Territory policies and funding programs in order to better (i) reflect the professional, theoretical, political and economic landscapes which exist now (eg. new theories, refinements in practice, greater numbers of students with disabilities participating in higher education and more severe/ multiple disabilities being accommodated at greater expense) (ii) support the efforts of universities providing comprehensive high quality disability services.

[2] Commonwealth/State Disability Agreement process to review and standardise as much as possible policies and funding programs in relation to students with disabilities in the States and Territories.

1. Criteria used to define … and to differentiate between disabilities

1.1 **World Health Orgnaization's distinctions still not well understood**: WHO developed its first International Classification of Impairments, Disabilities and Handicaps (ICIDH) in 1980. This is a very important document that makes distinctions that remain relevant today. However, they are still not used effectively by policy-makers and program-developers more than 20 years later.

- An **impairment** is a malformation of a person's body existing at birth (eg. spina bifida or intellectual impairment) or arising from subsequent trauma or disease (eg. spinal cord injury or Keratoconus resulting in blindness).
- A **disability** is a lack, loss or diminution of function arising from an impairment (eg. paralysis or deafness) or health condition (eg. chronic pain or fear of crowds) which creates limitations for people in the particular sphere they are in [2].
- A **handicap** is what is 'put in the way of' people with impairments or health conditions eg. (i) stairs - cause restriction of dignified and independent access to buildings or (ii) non-universal warning systems (sirens only) – potentially place Deaf people at greater risk in emergencies.

1.2 **WHO's ICIDH-2**: In 2001 the World Health Organization released a new, even more useful International Classification of Functioning and Disability referred to as ICIDH-2. ICIDH-2 is now operational. The media notes accompanying the release for field trials (1999) are reproduced in Appendix A. In part they state:

The ICIDH-2 "recognises the fact that a diagnosis of diseases and disorders, while important for clinical and public health needs, is not sufficient to describe the functional status of the individual and also to predict, guide and plan the various needs of such an individual.

The overall aim of the ICIDH-2 classification is to provide a unified and standard language and framework for the description of human functioning and disability as an important component of health. The classification covers any disturbance in terms of "functional states" associated with health conditions at body, individual and society levels."

1.3 **WHO Psychiatric Disability Schedule (WHODAS):** the first WHODAS was published by WHO in 1988 to provide a simple tool for assessing disturbances in social adjustment and behaviour in patients with a mental health condition. In 2001 the WHO released their second version of Schedule known as WHODAS II. This current version represents a complete revision, reflective of WHO's current thinking about functioning and disability.

Suggestion for consideration by the Committee:

[1] DEST to adopt and promote WHO classifications and schedules as a basis for standardising definitions and use of terminology across governments, educational institutions and disability services.

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[2] A person with spina bifida may have a disability in relation to walking but that same person does not have a disability when it comes to appreciating music.

2. Accuracy of needs assessment

The accuracy or quality of assessments of students' disability-related requirements[3] depends on what is agreed to be the purpose of the assessment and the experience and skills of members of different professional groups.

2.1 **Professional groups involved in assessment and documentation**: groups who claim to have the experience and skills necessary to provide accurate assessments of the disability-related requirements of students include (but may not be limited to):

- Audiologists
- Ear, Nose & Throat Specialists
- General Practitioners
- Medical specialists
- Optometrists (Behavioural)
- Ophthalmologists
- Physiotherapists
- Psychiatrists
- Psychologists (general)
- Psychologists (educational)
- Special Education Teachers

2.2 **Four major problems in assessment and documentation of requirements**:

2.2.1 **Insufficient expertise**: members of some professional groups provide assessments and documentation of impairments or health conditions in areas in which they do not have sufficient expertise (eg. optometrists are concerning themselves with neurological conditions and general/child psychologists attempt to assess Learning Disabilities in adults). This situation has the effect of seriously reducing the reliability of assessments and documentation with consequences for eligibility and the delivery of appropriate services.

2.2.2 **Lack of clarity**: Some professionals involved in assessing disability-related requirements seem to be unable to speak or write plain English. In fact, it appears they endeavour to mystify the services they provide. Consequently, those responsible for meeting disability-related requirements (eg. departmental officers, teachers and DLOs etc.) cannot be certain of who is eligible and/or requires what.

2.2.3 **Lack of understanding of what is involved**: it is important that those responsible for the quality of disability services not only know about disability but also are aware of precisely what functions and activities will be required for each education or training course – so a close comparison can be made between what has to be done and what impact the

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[3] One has built up a resistance over time to the use of the word 'needs' in this context because it smacks of charity. The fact is that, under our legislation, students with disabilities are entitled to require reasonable accommodations.

impairment/health condition is likely to have on those functions and activities.

For example, traditional higher education courses might be expected to require the functions and activities listed in Figure 1 in Appendix C. By contrast, a Geography course might involve all of the functions and activities listed plus 'motility' to enable the student to undertake excursions to rural sites in buses over rough ground. A Chemistry course is very likely to specifically require 'standing' so as to work at laboratory benches and in fume cupboards.

2.2.4 **Lack of guidelines**: Most professionals involved in assessing disability-related requirements have no idea of what sort of information is required for disability-related requirements to be met. The professionals know how to describe an impairment or health condition but, in the absence of guidelines as to what is required by program officers/teachers/ DLOs, they may not make useful recommendations. In other words, the information they supply often needs interpretation and guesswork before anyone can act on it. Poor communication leaves gaps in which mistakes and inaccuracies can occur.

2.2.5 **Very high cost**: The fourth major problem is the very high cost of assessment and documentation of disability for students – especially for those with Learning Disabilities and Attention Deficit Disorder. Proper assessments for these groups may cost between $450 and $900. To be of any value, these assessments must be comprehensive and exhaustive (eliminate possible alternative diagnoses) and be conducted and reported on by fully qualified educational psychologists experienced in working with adults [4].

When the costs of proper assessment and documentation are high, individuals and institutions may seek cheaper alternatives (eg. employing students to conduct the assessment or conducting only one test instead of 4 or more). This inevitably results in a lessening in quality and accuracy of the assessment provided.

Suggestions for consideration by the Committee:

[1] DEST and other relevant departments to discuss and jointly designate which professional groups will be encouraged to provide assessments and documentation of the impact of particular impairments or health conditions.

[2] DEST and State/Territory departments to develop and promote joint guidelines for professional groups as to what should be included in assessments and documentation of disability-related requirements.

[4] For more details see Australian Guidelines for the Documentation of Learning Disability in Adolescents and Adults at http://student.admin.utas.edu.au/services/alda/index.html

[3] DEST and State/Territory departments to (i) investigate ways of maintaining standards in 'needs' assessment and documentation and (ii) lowering costs for students with disabilities (and their families) by subsidising proper assessment processes.

[4] DEST and State/Territory departments to research, agree on and promote ways of increasing understanding of what is involved in undertaking education at whatever level in whatever course[5]..

3. Needs of students with disabilities in other disadvantaged groups

3.1 Low socio-economic

3.1.1 **Costs for students and their families:** it is widely acknowledged that living with an impairment or health condition (medical or mental) invariably means considerable additional costs for a family and, subsequently, for the adult individual.

3.1.2 **Commonwealth benefits inconsistent:** Many students with disabilities have low incomes or come from families with low incomes but they may not eligible to receive a Disability Support Pension. Therefore, these students must claim Youth Allowance or Austudy. Students with disabilities on Austudy are able to undertake a reduced workload (to 66% of full time study) in consideration of their disability but students with disabilities claiming Youth Allowance cannot. This highly unsatisfactory situation seems to be further complicated by the age of students.

3.1.3 **Time limits discriminatory**: postgraduate students with disabilities undertaking higher degree research under the research training scheme may, because of their disability, be unable to complete their studies within the time limits set for all students and their funding is withdrawn. This is indirect discrimination.

3.2 NESB and ATSI

I have no specific comments to make in this area.

3.3 Rural and remote

3.3.1 **Access to proper assessment and management advice:** rural and remote areas do not have the range or numbers of professionals to provide (i) timely, high quality assessment of requirements or (ii) advice to the individual as to how to manage a disability themselves or (iii) teachers/DLOs/those responsible for meeting disability-related requirements can learn from visiting experts. The lack of access means cost/inconvenience visiting the nearest city or no assessment/advice.

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[5] The broad functions are: Auditory, Cognitive, Communicative, Manipulatory, Motile, Personal organisation, Social, Visual. Under each of these can be listed a number of activities associated with the functions. Some activities involved in a traditional higher education course (as exemplified perhaps by English Literature today), are provided in APPENDIX C.

3.3.2 **Access to specialised support services:** living in a rural or remote area may also mean very limited access for students with disabilities to specialised support services such as sign interpreting, appropriate transport, reading or typing etcetera.

3.3.3 **Assistive technologies:** frequently students with disabilities in rural and remote settings are unable to acquire up-to-date equipment (eg. notebook computers or scooters) or the latest accessible software. Even if they are able to acquire such equipment or software, there are then even more intractable problems associated with finding skilled people to maintain the equipment or provide training in the use of software/hardware.

Suggestions for consideration by the Committee:

[1] Review and adjust eligibility criteria and benefits in social security payments for students with disabilities especially those in rural and remote areas.

[2] DEST and other relevant departments (State/Territory and Federal) to investigate ways of encouraging members of relevant professional groups (see Introduction) to travel on rotation to regional centres to deliver their services.

[3] DEST in cooperation with local governments, to develop programs to facilitate the provision of services and properly-resourced equipment loans programs.

4. Early intervention programs

I have no comment to make this area.

5. Funding and support programs

5.1 **Higher Education Equity Program (HEEP)**: The Higher Education Equity Program (HEEP) was originally intended to assist universities to provide services in support of all six disadvantaged groups[6] identified in the (1990) discussion paper A Fair Go for All.

Two factors (promulgation of the Disability Discrimination Act in 1993 and increasing costs associated with the delivery of services to students with disabilities) combined to create a tendency for universities to use HEEP funds almost exclusively for disability services. This situation gives rise to resentment towards students with disabilities.

HEEP funds have not been increased even though number of students with disability-related requirements has increased exponentially.

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[6] Besides people with disabilities, the other disadvantage groups identified in this paper were members of low socio-economic, non-English speaking background, Aboriginal and Torres Strait Islander people, rural and remote groups and women in non-traditional courses.

5.2 **Rolling disability funding into general funds**: Over the last 10 years it has been rumoured regularly that 'tagged' HEEP funds would be rolled by the Department into general funding received by institutions. Each time this has occurred DLOs have been able to demonstrate to DEET/DETYA/DEST Officers that such a step would inevitably lead to a reduction in the existing range and quality of disability services in higher education. This situation has not changed.

5.3 **Funding for research** into the currency and quality of services: since the very regrettable diversion by DETYA of all funds from the Disability Initiatives Program into Regional Disability Liaison Officer Program in 2000 there is practically no funding (***EIP and HEIP*** are unreliable and inadequate sources of research funding in the disability area) for thorough research into the currency or quality of disability services in education.

As a result of the lack of funds for research, Australia is slipping behind the rest of the world when it comes to the quality of its disability services and, consequently, the effectiveness of its funding allocation decisions.

5.4 **High cost support needs**: The recently introduced program to provide additional funding for students with high cost support needs is a positive move especially for universities which have much greater costs in line with well-deserved reputations for providing high quality services for students from particular disability groups (eg. RMIT for Deaf students). However, there are inherent difficulties, concerns and uncertainties for all universities wishing to apply and comply with the requirements of the program.

5.5 **Maintaining the benefits of earlier support programs**: Where support programs are introduced it is vitally important that the programs are maintained or 'refresher' programs are offered so that participants can refresh the skills and experience they acquired before. This is necessary because, without the opportunity to practice skills, many students with disabilities arrive in higher education very seriously under-prepared to manage their disability in a new environment. Under-prepared students are more likely to fail or drop out.

Suggestions for consideration by the Committee:

[1] DEST to restore HEEP for funding services for all equity groups except students with disabilities so that students with disabilities are not resented.

[2] DEST to develop in discussion with AV-CC, a more effective funding program for higher education students with disabilities encompassing perhaps a matching 1:1 arrangement requiring strict annual reporting arrangements.

[3] Keep all support program funds 'tagged' for specific groups.

[4] Restore the Disability Initiatives Program at a minimum of $750,000 per annum thus reactivating the sector's capacity to conduct research and thus inform theory and practice in the provision of quality disability services.

[5] DEST to review in discussion with AV-CC the new 'high support needs' program in order to make it more responsive to variable needs.

[6] DEST to ensure that support programs offered to students with disabilities in the future all contain a 'refresher' element so that students do not lose skills and thereby be placed at risk of failing or dropping out.

[7] Another strategy would be to work with universities and TAFE institutes to increase the number of secondary to tertiary transition programs for students with disabilities.

6. Integration of students with disabilities into mainstream education

I have no comment to make this area.

7. Initial training and professional development

The quality of disability-related services in higher education depends in very large measure on the capacity of all groups engaged in education service provision [7] to recognise, understand and accommodate disabilities efficiently and effectively.

7.1 **Training**: while efforts are being made to increase the teaching skills amongst university lecturers and tutors it is still the case that (i) few of the training opportunities offered to this group include consideration of inclusive/universal teaching methods (ii) other professional groups in higher education are not offered this either.

7.2 **Acquiring appropriate attitudes and necessary skills**: All professional groups working with students with disabilities should be offered professional development in the acquisition of appropriate attitudes and the necessary skills in working with students with disabilities.

Appropriate attitudes can be described briefly as making *neither too many concessions* for students with disabilities (this only sets up resentment against students with disabilities) *nor discriminating directly or indirectly* against them. Above all, appropriate attitudes do not include insisting on treating all students exactly the same – this is tantamount to indirect discrimination against students with disabilities.

7.3 **Provision of adequate resources**: staff acquiring appropriate attitudes and necessary skills need opportunities to rehearse and delivery on these positive attributes. They cannot do so if they are not provided with the resources to do so (eg. money to employ a sign interpreter, time to provide additional discussion and advice, people/assistants to make photocopies of overheads for students with vision impairments).

7.4 **DLO qualification**: currently DLOs do not have a base qualification (postgraduate level) and, because DLOs are drawn from many different professional backgrounds (eg. teaching, special education, psychology, science,

[7]. These groups include course designers, teachers, learning support staff and performance assessors/examiners and DLOs.

occupational therapy, physiotherapy, nursing, research), there is a lack of consistency across the nation in the focus and quality of disability services.

Suggestions for consideration by the Committee:

[1] DEST plus State/Territory governments and all education/training institutions to ensure that teacher training and/or professional development for academics/lecturers/ tutors contain units addressing effective interaction with students with disabilities.

[2] DEST plus State/Territory governments and all education/ training institutions to incorporate into training programs opportunities for staff to acquire appropriate attitudes and skills in delivering inclusive/universal services to students with disabilities in any area – especially course design, teaching, learning support and academic assessment.

[3] DEST in discussion with universities and TAFE institutes to set in place programs to encourage staff to adopt appropriate attitudes and skills and to include consideration of these in performance assessment and promotion processes.

[4] DEST in discussion with universities and TAFE institutes to put in place programs to ensure that all staff are provided with sufficient resources to enable them to deliver services without stress/ resentment (against students with disabilities).

[5] DEST, in discussion with universities already providing disability studies programs, to design and offer on a fee paying basis, (i) a base postgraduate qualification for DLOs and those wishing to enter the field and (ii) further education opportunities for DLOs and researchers wishing to specialise in education for students with disabilities.

8. Implications of current legislation

I have no comment to make this area beyond observing that, because of the imperative to conciliate embedded in the DDA, there is little case law available to provide clear examples of what is appropriate behaviour/policy/practice.

B: ROLE OF THE COMMONWEALTH AND STATES/TERRITORIES IN SUPPORTING THE EDUCATION OF STUDENTS WITH DISABILITIES.

The proper role of Commonwealth and States/Territories governments and the relevant government departments is to interact more closely (ie less combatively) with each other and work more effectively together and with other stakeholders (ie. students with disabilities, kindergartens, schools, colleges, institutes and universities) to ascertain what are appropriate future steps – with regard to the development of appropriate policies and support and funding programs to assist students with disabilities.

Gilli M Bruce
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6 May 2002

APPENDIX A

World Health Organisation - Note for the Press No 19 - 20 August 1999
http://www.who.int/inf-pr-1999/en/note99-19.html

INTERNATIONAL CLASSIFICATION OF FUNCTIONING AND DISABILITY: A NEW RELEASE FROM WHO

The World Health Organization (WHO) has released a new version of the International Classification of Functioning and Disability (Beta-2 version of ICIDH-2) for field trials. This is the last version to be tested and commented on throughout the world before it is finalized and submitted to the World Health Assembly in 2001. Field trials are due to finish in July 2000 and this version is open for comments by all individuals and organizations.

This is the first time that any type of international classification system is open to comment and possible amendment via the web. The classification is available in two versions, the Full and Short Versions, and both can be downloaded from the WHO website (http://www.who.int/icidh) and commented on category by category.

This classification, originally developed in 1980 as a manual for consequences of disease, complements the International Classification of Diseases (ICD-10) and now deals with functional states (i.e., mobility, social integration, etc.) associated with health conditions. It (ICIDH-2) recognises the fact that a diagnosis of diseases and disorders, while important for clinical and public health needs, is not sufficient to describe the functional status of the individual and also to predict, guide and plan the various needs of such an individual.

The overall aim of the ICIDH-2 classification is to provide a unified and standard language and framework for the description of human functioning and disability as an important component of health. The classification covers any disturbance in terms of "functional states" associated with health conditions at body, individual and society levels. ICIDH-2 organizes information according to three dimensions: [1] body level; [2] individual level; and [3] society level.

1. The Body dimension comprises two classifications, one for functions of body systems, and one for the body structure. The chapters of both classifications are organized according to body systems.
2. The Activities dimension covers the complete range of activities performed by an individual. The chapters are organised from simple to complex activities.
3. The Participation dimension classifies areas of life in which an individual is involved, has access to, and/or for which there are societal opportunities or barriers. The domains are organized from simple to complex areas.

A list of environmental factors forms part of the classification. Environmental factors have an impact on all three dimensions and are organized from the individual's most immediate environment to the general environment.

ICIDH-2 is a multi-purpose classification designed to serve various disciplines and different sectors. It aims:

Appendix A cont'd

* to provide a scientific basis for understanding and studying the functional states associated with health conditions;
* to establish a common language for describing functional states associated with health conditions in order to improve communications between health care workers, other sectors, and disabled people/people with disabilities;
* to permit comparison of data across countries, health care disciplines, services and time;
* to provide a systematic coding scheme for health information systems.

The Beta-2 version has been developed after extensive international field trials of the Beta-1 version over the last two years in which a large number of centres from all regions of WHO took part. Disability groups and associations were actively involved in the revision process.

ICIDH-2 is not just about people with disabilities; it is about all people. The functional states associated with all health conditions at body, individual or society level can be described using ICIDH-2: ICIDH-2 has universal application.

Although ICIDH-2 is inherently a health-related classification, it is also used by other sectors such as insurance, social security, labour, education, economics, social policy and general legislation development. It has also been accepted as one of the United Nations social classifications and is referred to in and incorporates the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities. ICIDH-2 thus provides an appropriate instrument for the implementation of stated international human rights mandates as well as national legislation.

Hard copies will soon be available from: Marketing and Dissemination
World Health Organization
CH-1211 Geneva 27
Switzerland

These can also be ordered on the Website (http://www.who.int/dsa) or at e-mail bookorders@who.ch

The classification is being translated in all the major languages of the world and information on these is available from the WHO.

For further information, journalists can contact Gregory Hartl, Office of Press and Public Relations, WHO, Geneva. Telephone (41 22) 791 4458. Fax (41 22) 791 4858. Email: hartlg@who.ch . Or: Dr. T. Bedirhan Üstün, Assessment, Classification and Epidemiology Group, WHO, Geneva, Tel (41 22) 791 3609. Fax (41 22) 791 4885. E-mail: ustunt@who.ch

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APPENDIX B

WHO Disability Assessment Schedule II
http://www.who.int/icidh/whodas/generalinfo.html

The World Health Organization Disability Assessment Schedule II (WHODAS II) assesses day to day functioning in six activity domains. Results provide a profile of functioning across the domains, as well as an overall disability score.

History of the WHODAS II

The WHO Psychiatric Disability Schedule (WHODAS) with a Guide to its Use was initially published by WHO in 1988 to provide a simple tool for assessing disturbances in social adjustment and behaviour in patients with a mental disorder. The current version (WHODAS II) represents a complete revision, reflective of WHO's current thinking about functioning and disability.

Psychometric testing of the WHODAS II has been rigorous and extensive. In 1998, an earlier draft (89 items) was tested in field trials in 21 sites and 19 countries. Based on psychometric analyses and further field testing in early 1999, the measure was shortened to 36 items, and a 12-item screening questionnaire was also developed. In late 1999, The WHODAS II underwent reliability and validity testing in 16 centres across 14 countries. Health services research studies (to test sensitivity to change and predictive validity) are being conducted in centres throughout the world during 2000.

WHODAS II Quick Facts

Publisher	World Health Organization
Date of Publication	Under development – expected 2001 general release
Appropriate Ages	Adults aged 18 and over
Norm Groups	This instrument is cross-culturally developed, and applicable across the spectrum of cultural and educational backgrounds.
Minimum Reading Level	Literacy is not necessary for completion of this instrument. Written and verbal prompts are provided to respondents to aid memory for key information. Proxy versions also are available.
Administration Time	12-item versions: 5 minutes 36-item versions: 20 minutes

Results of the WHODAS II can be used to help:

* Identify needs
* Match patients to interventions
* Track functioning over time
* Measure clinical outcomes and treatment effectiveness

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APPENDIX C

Figure 1: Some functions and activities needed to participate in more traditional higher education courses such as English Literature[8].

PREPARATION
- Doing preparatory reading or required study the night before
- Getting enough sleep/rest during the night

GETTING TO CAMPUS
- Getting out of bed in time
- Travelling/ arriving on time

GETTING TO CLASSES
- Finding/ remembering the way to a particular classroom
- Perceiving/reading signs
- Mobility eg. from bus/taxi/car along paths, up stairs

PARTICIPATING IN CLASSES
- Attending to auditory / kinaesthetic/ visual stimuli
- Avoiding distractions (sound, vibration and movement)
- Behaving appropriately in the setting
- Coping with crowds
- Coping with venue conditions eg. location, temperature, light.
- Handwriting – legible/ fast for notetaking
- Hearing
- Memory (short term) eg. (auditory) recalling what the lecturer just said
- Perceiving/ Comprehending what is heard/seen
- Reading (hand outs, overheads) – accurately/ quickly
- Seeing
- Sitting down/still for long periods

USING LEARNING SUPPORT SERVICES
- Being able to remember sequences/processes eg. library numbering system
- Dexterity – ability to turn pages/ manipulate mouse

UNDERGOING ASSESSMENTS/TESTS
- Thinking
- Memory (long term)
- Closure eg. being able to stop and move on to the next thing
- Recalling (long term) – information (also tasks and commitments)
- Written expression skills inc. grammar, punctuation and spelling

INTERACTING WITH STAFF & OTHER STUDENTS
- Confidence eg. to converse/ seek help/advice
- Self advocacy/ negotiating skills
- Speech/communication skills

Note: If, because of an the impact of an impairment or health condition on required functions and activities, a student is unable or has a reduced ability to undertake any of these activities, then the student has a disability of one degree or another in that area and will require some level of accommodation of the disability/ies amongst the education services he/she receives.

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[8] This table was developed by Gillian Bruce for her forthcoming publication: Working Effectively with Students with Disabilities in Australia: a handbook