

# DISABILITY AWARENESS: “*The Basics*”

PACER Center • Building Program Capacity to Serve Youth with Disabilities • **Session 1**

## 1) Project Overview

This youth development staff training curriculum is a product of Project *SWIFT* (Strategies for Workforce Inclusion and Family Training); a United States Department of Labor funded Innovative Demonstration Grant for Youth with Disabilities conducted by PACER Center in Minneapolis, MN from September 2001 to September 2003. Project *SWIFT*, along with partners in Minneapolis and Ramsey County, MN initiated project activities with the goal of increasing the inclusion of youth with disabilities in youth programs funded by the Workforce Investment Act (WIA). In addition, *SWIFT* also conducted parent training sessions to introduce parents of youth with disabilities to the wide variety of employment programs available to youth, including those found through the Workforce Investment Act. **The four main project activities of Project *SWIFT* were:**

- Training staff of WIA-funded youth employment and education programs
- Training families and youth about accessing youth program services
- Providing technical assistance to the staff of WIA-funded youth employment and education programs
- Disseminating information about the *SWIFT* project model

Trainings developed by Project *SWIFT* reflect the fact that PACER Center is a parent information and training center dedicated to improving outcomes for youth with disabilities and their families. PACER programs promote family involvement and collaboration between parents and professionals. This series of workshops incorporates family perspectives and family issues into each session. Session 5, however, focuses on these issues in more depth.

Both the WIA staff training curriculum and a parent-training curriculum can be accessed at PACER Center’s website ([www.pacer.org](http://www.pacer.org)).

## 2) Workshop Preparation Suggestions

When conducting a training workshop, there are several basic planning considerations that need to be made. Most of the trainers who use this curriculum will already have their procedures for workshop planning in place. This information is included for those who may need additional suggestions.

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### **3) Choosing the Site:**

Most curriculum users will have training sites which they regularly use. The following suggestions are listed for those who may need additional assistance and as a reminder to be sure to consider the accessibility needs of people with disabilities.

- There are several important considerations to be made when choosing a site for a workshop. They include physical accessibility of the building itself, parking, easy to find location and comfort and maneuverability in the room. For more resources to ensure that your meeting is accessible visit the Educational Resources Information Center (ERIC) website and read Digest E735: *Planning Accessible Conferences and Meetings*: <http://ericec.org/digests/e735.html>.
- When confirming the site, make sure arrangements for equipment such as overhead projector and screen, flip chart, and microphone and podium are in place. Also make sure there are nametags or name tents for participants to use. (Calling on someone by their name is much more personal and allows for the presenter to elicit participation of individuals who may not be as actively involved as others.)
- Make sure that directions to the site are clear and accurate and confirm them with another source such as a co-sponsor or contact person for the facility.

### **4) Introduction to the Workshop:**

The workshop usually starts with a transparency of the workshop's agenda and a quick overview highlighting the points to be covered, ground rules for questions, timing of breaks, location of bathrooms and literature tables, and other pertinent information.

### **5) Introduction of Presenters: 2 minutes**

- It is important to establish a feeling of warmth and openness to encourage attendees to fully participate, by talking about the questions and issues important to them. One way to model this is during the introduction process.
- If more than one of the presenters has a disability, this is a good opportunity to disclose that information. It can also be a time to identify the type of accommodations needed from the audience (e.g. raising your hand is not effective if the presenter is blind, speaking up if the presenter is hard of hearing, etc).
- Presenters can also share whether they are family members of people with disabilities or other personal connections they have to people with disabilities or disability issues.

## 6) Introduction of Attendees: 10 minutes

- Depending on the size of the audience (up to 35 attendees), you will want to limit the amount of time for their introductions. We suggest, since this is the first training and *kick-off* session in this training series to have each attendee at the very least, state their name and what organization they represent.
- Role model what you want stated and how quickly they should cover the information-- 15-30 seconds per person should be adequate.
- If the size of the group is too large, then there will not be enough time to allow for this type of introduction. Staff should then take a head count or send around a sign-in sheet.
- Another approach is to ask participants to write down three questions they want to make sure they get answered in the workshop. Then ask participants to check their list near the end of the session to ensure their questions were answered.

## 7) Agenda: 1 minute

*\*(Refer to the Agenda overhead transparency-slide 1)*

- Welcome & Introductions
- Definition of Disability & Diverse Disabilities
- History of Disability
- Exploring our own Attitudes
- Language and Disability Etiquette
- Resources
- Questions and Evaluations

This workshop explores basic elements of disability awareness. It is designed to be a general overview with more in-depth training sessions to follow. Other sessions address disability related laws and legislation, accommodations, assistive technology and more. *After* reviewing the agenda with participants, presenters should let people know how they will answer questions and when they will do so. Sometimes a workshop flows better if certain types of questions are dealt with during a particular segment of the agenda. Inform them at this time regarding questions, answers, and ground rules.

**-Close this portion by asking: *Q: Are there any questions?***

## 8) Opening Interaction: 5 minutes

**-Start this portion by asking attendees the following: *Q: How many of you know or have interacted with someone with a disability?* - Raise your hands.**

Acknowledge how many participants raised their hands. Explain that many people feel they do not have any experience or knowledge about disability and therefore are uncomfortable talking about the subject or minimize the knowledge they do have. Even if we've only had one encounter with someone with a disability, that encounter has shaped our perspective on disability.

**-Then ask: Q: How many of you have young people with disabilities in your youth programs that you know of? - Raise your hands.**

Encourage attendees to bring their experiences and knowledge around disability to the workshop discussion.

**-Last question: Q: How many have been to at least one training or workshop on disability, or the ADA law? - Raise your hands.**

As a presenter, knowing the knowledge level of your participants can help you to tap into the experience of your audience. Invite them to bring their expertise to the discussion. This approach will help to engage individuals who have some familiarity with the subject and who otherwise might find the information redundant.

## **9) Definition of Disability: 13 minutes**

Disability crosses every social, economic, gender, religious and ethnic boundary. Anyone at any time can become disabled. One can become disabled by being born with a disability; or can acquire one by an accident (automobile, skiing, falling, etc.); or illness (being diagnosed with Lupus, MS, arthritis, etc.) or the natural aging process. We as a society are living much longer than our ancestors. In addition, medical technology has progressed so rapidly that it has allowed people with disabilities to live longer with their disabilities with the help of equipment and health aids that were not available even 20 years ago.

**-Ask the group: Q: What is a disability?**

*\*(Refer to the Definition of Disability overhead transparencies: slides 2 & 3)*

For the purposes of this discussion today, and because of our focus on helping youth with disabilities move into the workplace, we are going to begin our discussion of disability by looking at the definition of the term found in the Americans with Disabilities Act (ADA). The ADA's protection applies primarily, but not exclusively, to "disabled" individuals. **An individual is "disabled" if he or she meets at least one of the following:**

- Anyone with a physical or mental impairment that *substantially* limits one or more of the major life activities:
  - Walking -Hearing -Breathing -Speaking
  - Standing -Thinking -Learning -Sitting
  - Working -Seeing -Self-care

The ADA law does not emphasize a specific list of conditions that might constitute a disability, but focuses on how it affects a person's *major life activities*.

- He or she has a record of such impairment.

People with disabilities who are denied a position or promotion, or are fired due solely to the existence of *documentation* about their disability are also protected by this law.

- He or she is regarded as having such an impairment

Someone who is discriminated against because others *assume* they are disabled (e.g. due to facial disfigurement, scarring from being in a fire, etc.), even if they do not in fact have a disability, can be covered by the ADA.

- Other individuals who are protected in certain circumstances include 1) those, such as parents, who have an association with an individual known to have a disability, and 2) those that are coerced or subjected to retaliation for assisting people with disabilities in asserting their rights under the ADA.

People who are “associated” with people with disabilities are also protected from disability discrimination. This can include parents, siblings or friends of people with disabilities. For example, if a restaurant refuses to serve a family because one member has a disability, the entire family could make a formal complaint under the ADA. Also, a parent cannot be refused employment, promotion, or insurance coverage available to fellow employees or suffer any other discrimination because they have a child with a disability.

## **10) Basic Statistics: 2 minutes**

*\*(Refer to the Lou Harris Poll overhead transparency-slide 4)*

### **According to the 1998 Lou Harris Poll:**

- 54 million Americans have a disability
- 29% of working age individuals (18-64) with disabilities work full time
- 79% of working age individuals without disability work full time

*(Presenters should note the significant differences in percentages between the two populations.)*

## **11) Youth in Corrections: 10 minutes**

One of the target populations served by WIA funded youth programs is youth who are considered “at-risk”. This category includes youth who are currently in the juvenile justice system. The following statistics demonstrate that a good percentage of youth in the juvenile justice system are likely to have some type of disability.

### **Statistics:**

*\*(Refer to the Juvenile Justice overhead transparencies: slides 5 & 6)*

- Estimates of youth involved with juvenile corrections that have **any** type of disability range from 32%— 80%.

Hidden Disabilities:

- 17% — 53% have a specific learning disability
- 19% — 78% have an emotional disturbance
- 19% — 46% have Attention Deficit Disorders

In contrast, youth with easily identifiable disabilities are less represented in juvenile justice:

- 7% — 15% have mental retardation
- 1% — 6% have psychoses or autism

*(These statistics are estimates and may not represent your local or state population. As you can see, there is not firm data on the number of youth in the juvenile justice system that have disabilities. However, even the minimal estimates demonstrate a significant presence of disabilities in this population.)*

In addition:

- The number of youth referred to adult corrections has steadily increased.
- Youth of color with disabilities are over-represented in both the juvenile justice system and criminal justice systems.
- Advocates argue that the juvenile justice system is focusing less on rehabilitation and more on retribution.
- Many youth are placed in correctional settings because of behaviors associated with a variety of emotional and behavioral disorders.
- Many youth with disabilities are not receiving the educational and mental health services to which they are entitled.

*(NOTE: Youth with disabilities who have been involved in the juvenile justice system will most likely require more preparation for the job market. Consider how their particular disability could affect their job performance and career goals, and what accommodations they may need on the job.)*

## **12) More about Disability...: 20 minutes**

Now that we have covered the legal definition of the ADA and highlighted some statistics, let's talk about a broader perspective on disability. There are many types of disabilities. Examples include multiple sclerosis (MS), learning disabilities, Deafness, blindness, Down Syndrome, mental illness, epilepsy, Parkinson's disease, muscular dystrophy (MD), paraplegia,

quadriplegia, developmental disabilities, and the list goes on. Before we explore the phenomena of disability further, it is important to remember that *a person is more than their disability*.

**Many things affect an individual's experience with disability:**

- medical diagnosis or “label”
- personality
- how long they've been disabled
- economic status
- cultural background
- upbringing
- families and friends views of and comfort levels with disability
- educational background
- religious background and/or beliefs and much more

All these elements combined contribute to an individual's identity – not just the disability “label” or medical diagnosis.

*\*(Refer to the Diverse Disabilities overhead transparency-slide 7, also refer to the handout, “Categories of Diverse Disabilities”)*

We have divided some of these disabilities up into categories. There is no one universally accepted approach to describing categories of disabilities. The categories used in this workshop incorporate terms found in special education, disability legislation, and medical literature. It is important to remember that within each category of disability there are differences between individuals in the type, degree, and impact of their disability. In addition, a person may have more than one disability.

**Congenital vs. acquired**

*Congenital* means “since birth” or being born with the disability such as cerebral palsy or spina bifida. *Acquired*, on the other hand, means becoming disabled by an illness or accident. Actor Christopher Reeve (who played ‘Superman’ in the movies) became a quadriplegic in a horse-back riding accident in the early 1990's.

Former U.S. Attorney General Janet Reno, and actor Michael J. Fox, both publicly announced that have been diagnosed with Parkinson's disease -- which they did not acquire until they were well into adulthood.

**Visible vs. hidden disabilities**

**-Ask participants: Q: *What are some visible disabilities?***

Elicit answers and add to their responses if not included: *paraplegia or quadriplegia, blindness if a person is using a service dog or using a white cane, cerebral palsy, spina-bifida.*

**-Then ask the group: Q: *And what are some hidden disabilities?***

Again if not mentioned include: *mental illness, MS – depending on the symptoms, learning disabilities, chronic pain, Lupus, arthritis, head injury, epilepsy, AD/HD.*

Although we may not know someone has a disability because there's no visual clue, this does not mean they don't have a legitimate disability and may need an accommodation. Hidden disabilities may make the situation more difficult to determine and requires good communication to explore what works best. Though an individual with a disability is not required by law to self-identify as disabled, understand that if they need or want services or accommodations due to their disability, they will need to self-identify.

### **Sensory disabilities**

*Sensory disabilities* are those that affect our senses, such as blindness and visual impairments. There's also those who are Deaf or are hard of hearing. Almost all disabilities have a degree of severity, from mild to severe. One can be totally blind, having no vision, not able to see shapes, shadows, etc. Then there are those who have some vision loss, are able to see outlines of things and people, shadows and colors, but their vision is significantly impaired. One can be born with or acquire sensory disabilities. Many of these disability categories can overlap.

### **Developmental disabilities**

*Developmental disability* is a category that encompasses many disabilities such as, cerebral palsy, autism, mental retardation, epilepsy and spina bifida as well as other neurological impairments. **The Developmental Disability Assistance and Bill of Rights Act of 2000 defines the term developmental disability using the following criteria:**

- The disability occurred before age 22
- The disability is likely to continue indefinitely
- The disability substantially effects functional limitations in three or more areas including:
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency

### **Progressive disabilities**

*Progressive disabilities* are just that – progressive. It is when the symptoms or condition change or worsen with time. In the case of MS, the symptoms can be very diverse, unpredictable and can differ from person to person. One may experience vision impairments, fatigue, muscle coordination, and slurred speech, and someone else may experience bladder and bowel problems, difficulty walking, mood swings and short-term memory loss. And yet, they both have the diagnosis of MS.

**-Ask participants: Q: Any questions about any of this?**

## **13) History of Disability: 10 minutes**

In the United States, the history for many people with disabilities has been separation, isolation, shame and institutionalization. Society's fear, assumptions and stereotypes about people with

disabilities is what has caused this isolation and discomfort about being around or hiring people with disabilities.

*\*(Refer to the handout, "History of Disability" and discuss a few of the items that you find interesting or relevant. Presenters can find an in-depth presentation of this information on the web site of the Minnesota Governor's Council on Developmental Disabilities: [www.mndcc.org](http://www.mndcc.org))*

A significant part of disability history in this country reflects society's perception of people with disabilities as medical problems that need to be "fixed". Increasingly, however, society is starting to understand that people with disabilities are as capable as others, as worthwhile as others, and able to fully participate in life's experiences, responsibilities and personal growth.

**-Ask participants: Q: *How might these historical attitudes toward disability still influence youth with disabilities and their families?***

One way to discuss these changes in attitude is to use the "interactional model of disability" developed by Dr. Carol Gill from the Chicago Institute on Disability Research *\*(Refer to the handout "Two Models of Disabilities: A Contrast")*.

### **Two Models of Disability: A Contrast:**

#### **Medical Model vs.**

Disability is a deficiency or abnormality.

Disability is a negative.

Disability resides in the individual.

The remedy for disability-related problems is cure or normalization of the individual.

The agent of remedy is professional.

#### **Interactional Model**

Disability is a difference.

Being disabled in itself is neutral.

Disability derives from the interaction between the individual and society.

The remedy of disability-related problems is change in the interaction between the individual and society.

The agent of change can be the individual, an advocate, or anyone who affects the arrangements between the individual and society.

An unfortunate result of the medical model of disability is isolation. The medical model stresses fixing the disability so the person can be integrated into society. It is important to note the conceptual difference between "integration" and "inclusion". Al Condeluci Ph.D., CEO of UCP Pittsburgh describes the difference this way: "Integration supposes that the minority group, in this case persons with a disability, have to change to fit into society. Essentially the message is

that you are not good enough the way you are. Inclusion on the other hand holds that society should adapt to the person. Everyone brings different strengths and talents to the table, and you can sit at the table just the way you are.”

**-Close this section by asking: *Q: Any comments or questions about any of this?***

## **14) Our Attitudes about Disability:** *group exercise, 2 minutes for explanation*

A large group discussion can be held about attitudes and to explore what participants currently think they know about disability.

The point of this exercise is to examine:

- participant assumptions about disability
- possible assumptions of youth about disability
- possible assumptions of family members about disability
- how everyone’s assumptions and past experiences affect interactions, decisions and comfort level with disability

**Ask everyone to (individually) jot down:**

***-1) What is the disability you FEAR the most – one that you feel you would never want to have, based on what you currently know about it.***

***-2) list your FIVE favorite activities, things you love to do. Could be hobbies, interests, whatever. Do this quickly, right off the top of your heads.***

### **Group instructions for exercise**

Hand out sheets of blank flipchart paper & markers to each group.  
*(Allow 15 minutes for small group discussion)*

Break the large group into small groups of 3 to 5 people. Instruct groups to identify a “note taker” who will write the group’s answers on the flipchart paper. Also identify the person who will report back to the large group.

Have the small groups discuss the following:

- List the DISABILITIES each member of the group identified.
- List the ways in which each disability would have a significant negative impact on your life.
- List participant concerns about how their favorite activities would be affected by each of these disabilities.

-Inform groups that they have 10 minutes to complete these tasks.

-Once each group is done, have them tape their sheet(s) up on the wall

**Process this portion of the exercise as a large group: 30 minutes**

-Discuss each group's results as a large group. (Go around the room and have each group report their answers.)

**-Facilitate a discussion around the following questions:**

***Q: Which disabilities were chosen most often and why?***

***Q: What were the most often reported negative impact(s) people identified and why?***

***Q: Which activities would be affected and how?***

Facilitators may suggest specific accommodations that would allow individuals to continue their favorite interest despite having a disability.

Make sure to process the following points with the large group:

- There are a great many disabilities. Much fear comes from not having accurate information about them. WE ALL NEED TO CONTINUE TO LEARN AND EDUCATE OURSELVES ABOUT DISABILITY AND THE DISABILITY EXPERIENCE.
- Becoming aware of our own perceptions, stereotypes and discomforts around particular disabilities, is the first step towards addressing subtle biases that could possibly be projected onto youth with disabilities.
- This discussion and exercise is only an initial step towards understanding messages, stereotypes and beliefs we have learned, experienced and internalized about disability.

**Finally, in closing this portion of the session ask the following:**

***Q: Any further comments or questions about any of this?***

***Q: What did you think of this exercise? Did it get you thinking about disability and certain beliefs or perceptions that you might not have known you had?***

**BREAK: 10 minutes**

**15) Language: 15 minutes**

**-Ask the group: *Q: How many here have ever been uncomfortable communicating with a person with a disability because you felt you did not know the "proper" way to refer to certain things? – Raise your hands*** (Have attendees describe individual experiences if time allows.)

Professionals who work in service delivery systems may become uncomfortable when interacting with a person with a disability because the acceptable language used to refer to specific conditions, or disability as a whole, has a tendency to change. In this section, explain that the words we use to describe one another can have an enormous impact on the perceptions we and others have, how we treat one another, mutual expectations, and how welcome we make people feel.

The following are some basic suggestions for talking about, and with, an individual with a disability. While these suggestions can be helpful, keep in mind:

- If you're unsure how to refer to someone or what the appropriate current term is, ask!
- The best way to refer to someone with a disability is usually, like everyone else, by name.
- Refer to the person first, then the disability.
- Do not label people as part of a disability group. Say "people with disabilities", not "the disabled".
- A *disability* is a functional limitation that interferes with a person's ability to walk, hear, talk, learn, etc. Use the term *handicap* to describe the situation or barrier imposed by society, the environment or oneself.

*\*(Refer to the handout "It's the 'Person First' Then the Disability")*

Briefly discuss some highlighted items comparing alternative wording in the two columns.

**-End this discussion by asking the group: *Q: Any questions or comments about any of this?***

## **16) Disability Etiquette: 10 minutes**

*\*(Refer to the handout "Basic Disability Etiquette Tips")*

In this portion, briefly go through some of the following items. Include in the discussion, short personal stories that relate to the particular items you've chosen.

- *Never* assume you know what a person with a disability wants or needs.
- If offering any assistance, *always* wait for a response and then follow the individual's instructions.
- When talking to a person with a disability, talk directly to that individual, not the friend, companion or Sign Language interpreter who may be present.
- Respect all assistive devices (i.e. canes, wheelchairs, crutches, communication boards) as personal property. Unless given permission, do not move, play with or use them.
- Remember that people with disabilities are interested in the same topics of conversations as non-disabled individuals.
- When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear artificial limbs can usually shake hands. (Shaking hands with your left hand is an acceptable greeting.)

- If talking with a person using a wheelchair for any length of time, try to place yourself at their eye level. (*This is to avoid stiff necks and "talking down" to the individual.*)
- Do not look away while talking with someone who is Deaf or hard of hearing.
- *Do not* shout or raise your voice unless asked to do so.
- If greeting someone who is blind or has a visual impairment, identify yourself and those who may be accompanying you.
- Do not pet or make a service dog the focus of conversation.
- Let the individual who is blind or visually impaired know if you move or need to end the conversation.
- When interacting with a person who is visually impaired, follow their lead. If they need assistance, they will ask.
- Allow the person to negotiate their surroundings, e.g., finding the door handle, locating a chair, etc.
- Treat adults as adults. Address people with disabilities by their first name only when extending the same familiarity to all others.

**-Ask the group in closing: *Q: Any comments or questions about any of this?***

## **17) Wrap–Up: Review Key Points of Sessions: 5 minutes**

Briefly review what was covered today:

- Disability touches everyone in some way. It is not a small population, but one that is constantly growing and diversifying.
- There are many types of disabilities, visible and hidden.
- You are not expected to be experts on disability, but focus on the youth's capabilities, skills and interests.
- Our own beliefs and comfort level around disability has a major impact on how we view, interact and provide services and programs to youth with disabilities.
- The combination of language and behavior (disability etiquette) is important to be aware of. Always be respectful, follow the lead of the person with a disability, and don't be afraid to ask the person if you are unsure of what to say or do.
- You are not alone in this process! There is a lot of support and assistance available to you. There are numerous organizations, publications, and resources that focus on services for youth with disabilities. Two excellent places to start are the National Collaborative for Workforce Development-Youth website at [www.ncwd-youth.org](http://www.ncwd-youth.org) and PACER Center's website at [www.pacer.org](http://www.pacer.org).

**-Ask the group: Q: *So in closing, are there any other questions, comments, concerns about anything we covered today that you want to bring up before we move on to the evaluations?***

## **18) Resources:**

**Handouts:** 1) “Categories of Diverse Disabilities”  
2) “History of Disability in Brief”  
3) “Two Models of Disability: A Contrast”  
4) “It’s the ‘Person First’ Then the Disability”  
5) “Basic Disability Etiquette Tips”

**Resources:** 1) Refer to “Building Program Capacity to Serve Youth with Disabilities: *Resource List*”

## **19) Evaluations: *5 minutes***

Please take the last few minutes and fill out the evaluation form.

## **20) Close:**

Thank participants for their attendance, involvement, and interest in learning more about this topic.