



## MODELIZAÇÃO DAS POLÍTICAS E DAS PRÁTICAS DE INCLUSÃO SOCIAL DAS PESSOAS COM DEFICIÊNCIAS EM PORTUGAL

### THE ICF AS A FRAMEWORK FOR DISABILITY POLICY DESIGN AND DEPLOYMENT

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## Introduction

The appropriateness of adopting the International Classification of Functioning Health and Disability (ICF)<sup>1</sup> as an operational framework for developing a National Disability Strategy can be supported from a range of perspectives. This chapter provides a brief review of many of these from the perspective of policy makers, people with disabilities and the general population. The approach taken is, in the first place, to explore the most appropriate approach that should be adopted from an inclusive society perspective and review the ICF against these criteria.

At the heart of the Disability Debate is the question of 'them' and 'us'. This is a question that arises mainly from models of disability that create demarcations between people with and without disabilities. If one evaluates both the medical and social models from this perspective it becomes apparent that both approaches require the dichotomization of the population into disabled and non-disabled groups. However, if one takes the broad view of disability it is not difficult to conclude that most people in society will experience disability and impairment at some time in their lives. It is also clear that very many people are currently in the process of becoming disabled at any given time. Thus the argued in favor of characterizing disability as a dynamic continuum rather than a set of discrete and stable states is extremely strong.

Many arguments have been made against the adoption of a dynamic interactive model of disability model of disability as the basis for disability policy but most of them are either based on issues of feasibility and practicality or evolve from the institutionalized perspectives and positions of vested interests in the field. One of the main factors inhibiting the adoption of the approach to policy development and implementation is that most administrative, funding and regulatory mechanisms are predicated on a dichotomous model of disability. This partly because it is essential to allocate the scarce resources in the disability sector to those who are most in need and partly because it is convenient for those responsible for operating the system i.e. politicians, administrators, services providers and regulatory agencies.

The debate revolves around the dilemma facing Society and the State about who is 'eligible' for 'what'. Previous approaches to resolving this dilemma have attempted to base eligibility criteria upon the notion of disability as a stable and relatively permanent state or condition. But what emerges when examining these supposedly objective definitions of disability is that they differ not merely between Member States or jurisdictions but that even within the same jurisdiction the definition of disability differs depending on the intention of the statutory instrument in relation to resources and objectives. Fro example, eligibility for social security payments and long term disability payment tend to be far more stringent than eligibility for access to rehabilitation or social

inclusion programmes. Both of these often differ from the definition used in anti-discrimination legislation. In fact, what is clear that competent authorities have implicitly accepted that disability exists along a continuum from mild to more severe and have reflected this in setting out the socio-political criteria for eligibility for programmes and funding.

Once the link between questions of eligibility and the meaning of disability have been severed, there are very few arguments in favor of adopting a dichotomous model of disability as basis for policy forming and implementation. Further, once the decision has been made to accept that disability occurs across a dynamic continuum, there is effectively only one coherent framework that can be used to capture and characterise this from a policy and practical standpoint i.e. the ICF.

The ICF offers a useful hybrid description of disability that can be used by policy makers, researchers, people with disabilities, providers and administrators to come to a common understanding of the meaning of disability and which responds to many of the criticisms of both medical and social models. It also provides a comprehensive framework for operationalising that description.

In the words of Rachel Hurst, an international disability activist from the UK, who participated in the development of the ICF:

*The ICF, if properly used, supports the rights model of disability and will help us collect the evidence to show what our lives are really like. It also officially states that disability arises from the impact of environmental factors on impairment and functioning.<sup>2</sup>*

The ICF can be used to develop a matrix of measurable indicators of sustainable development and a society based on celebrating difference and ensuring rights for all, a society where disabled people's rights are underpinned and human dignity respected. – a society which could be helped by the ICF – then why not work towards this vision?" (2001)

The ICF is a classification that allows a comprehensive and detailed description of a person's experience of disability, including the environmental barriers and facilitators that have an impact on a person's functioning. The recognition of the central role played by environmental factors has changed the locus of the problem and, hence, the focus of intervention, from the individual to the environment in which the individual lives.

Disability is no longer understood as a feature of the individual, but rather as the outcome of an interaction of the person with a health condition and the environmental factors. The adoption of the interactive model and the impacts of environmental factors in all aspects of health and functioning that are explicit in the ICF is a step forward.<sup>3</sup>

The proper use of the environmental factors within the ICF will ensure appropriate policies, systems and services, provide measurable indicators for health status and sustainable development and underpin the recognition that disability is a human rights issue.<sup>4</sup>

Thus the ICF has a number of features which make it useful at the policy level. It has the capacity to incorporate both medical and social aspects of the disability process. It is a robust, coherent and systematic classification that can be used for describing and documenting the complexities of the disability process. Additionally, there are a number of other useful characteristics which make it an ideal instrument for designing and deploying disability policy within a jurisdiction.

### **Key characteristics of the ICF from a policy perspective**

#### Levels of Application

The ICF can be applied at an individual, institutional or societal level. It is capable of being applied in the case of a person experiencing a reduction in functioning as a result of a health condition to document that person's life experience, to specify appropriate interventions and to set target outcomes. Further, it provides a common language to facilitate communication between professionals.<sup>5</sup>

At the institutional level, it has the potential to describe the strategic objectives of an organisation operating within the field of disability, to contribute to the development of more holistic and relevant programmes, to structure research agendas, to contribute to the continuing professional development of staff and to provide the basis for quality standards and outcome evaluation.<sup>6</sup>

At a societal level, the ICF can be used to evaluate the current disability response within a jurisdiction, to identify where statutory and regulatory mechanisms are acting as barriers to full participation for people with disabilities and to provide a framework for the design of more inclusive and responsive policies.<sup>7</sup> The ICF has been particularly useful in the design of statistical studies to document the lived experience of people with disabilities and has been successfully used in adapting questions in a population census to reveal the distinction between impairment and participation. It has also been used in national disability studies to document the

impact of existing disability policies.<sup>8</sup> Thus, adopting the ICF as a framework for policy development means that the deployment of such policies can be systematically mapped at the institutional and individual levels. As a result, the evaluation of the impact of disability policy becomes easier.<sup>9</sup>

### Domains of Relevance

It is acknowledged that disability is a matter of concern across many policy domains. It is also accepted that a major disabling factor in society is the fragmentation of responses within and between different domains of policy. The desirable response to disability is one that is 'joined up' across policy domains. One major challenge in achieving cross-cutting disability policies is that the language of disability and definitions differ from one domain to another. For example, the way in which disability is usually described within the domain of health differs qualitatively from descriptions used in education, training or equality.

Each domain specifies its disability response either in legislation or through regulatory mechanisms. What is required is a way of conceptualising disability across policy domains which acknowledges the need for a diversity of definition and criteria for eligibility in each domain. The ICF provides a framework which can be applied within the domains of health, education and training, work and employment, social affairs, social inclusion, transport, communications, environment, justice and equality.<sup>10 11</sup> It does not require the unification or standardisation of criteria or strategies while at the same time each policy response can be mapped on the multidimensional axes of the ICF.<sup>12</sup>

### Specificity of Description

One of the fundamental strengths of the ICF is that it remains coherent at all levels of description. At the most general level, the ICF specifies the inter-relationships between health condition, functioning, activity limitation and participation restriction in the context of the intervening variables *environment* and *personal factors*.<sup>13</sup> At a policy level the environmental chapter specifies the range of policies, systems and services that are implicated in the disabling or enabling process within a jurisdiction. It can be used to characterise the impact of mediating mechanisms and systems of provision upon the lives of citizens with disabilities.<sup>14</sup> In combination with the ICD10 it can be used to provide a holistic description of the needs and strengths of an individual with disabilities.<sup>15</sup> The consistency with which the ICF describes disability from the general to the specific makes it an ideal tool for tracking the impact of policies on individuals.

### Sensitivity to Intervening Factors

An important characteristic of the ICF from the perspective of policy development is that at least at the framework level, it acknowledges that disability will impact differently upon people depending on a range of other factors. Thus, the meaning of disability for someone who is fifty-five years of age is very different to the experience of a person who is twenty-five years of age. It is also the case that disability can impact differently upon men as opposed to woman. Disability is viewed differently in different cultures and can be experienced differently depending on a person's ethnic origin. Disability will have different implications depending on a person's level of income and level of education. While the ICF acknowledges the importance of personal factors in the disability process, it stops short of documenting these within the classification. This is appropriate given that its primary function is to provide a systematic way of describing health, functioning and disability. Nevertheless, from a policy perspective acknowledging the importance of personal factors and demographics in the disability process can guard against 'one size fits all' approaches to disability policy.<sup>16</sup> The interaction between impairment and other factors such as social status and economic status can also be useful in specifying eligibility criteria for certain supports, programme and interventions.

### Scope of Activity

The ICF has been used at policy, research and individual levels in many jurisdictions to date. From a policy perspective it is regularly applied in the assessment of population health, in monitoring the impact of disability in both economic and social terms and in providing an evidence base for policy makers in relation to a range of policy interventions across the domains of health, social security, work and employment and education.

In particular the ICF highlights the importance of not simply documenting epidemiology but also evaluating the responsiveness of systems of provision, efficiency of delivery and the effectiveness of performance. Within the field of research the ICF is being considered in areas as diverse as public health,<sup>17</sup> social inclusion,<sup>18</sup> work and employment,<sup>19</sup> equality<sup>20</sup> and social security<sup>21</sup>. It is particularly useful in describing interactions between factors in the disability process, examining the complex relationships between structural and agency explanations of outcomes, facilitating multi-disciplinary research and evaluation programmes.

The ICF enhances the explanatory power of research particularly in relation to service utilisation, needs and outcomes and costs and impact. Within the field of health the ICF has broadened out the focus beyond that of impairment, has mainstreamed the concept of disability to the general

population, has provided common domains of description which are independent of diagnosis, helped to link data from both health and disability sources and emphasised the importance of environmental factors in planning supports and interventions.

At the level of clinical practice the ICF provides a structure for carrying out needs assessment, planning interventions and supports and monitoring outcomes and progress. The use of specific core<sup>22</sup> sets for different conditions provides a systematic and consistent approach which can be applied across policy domains, services and in different regions.

The ICF can also be useful in managing systems of provision in that it is ideally suited to the construction of electronic records, monitoring service performance, measuring consumer satisfaction, comparing the impact of different interventions and mapping utilisation patterns.

### Early Intervention and Prevention

One key contribution that the ICF makes to disability policy is that it broadens the focus of policy makers beyond the design and development of responses to people who are currently experiencing disability to include the need for policy, systems and services to prevent impairment and to intervene early, where an impairment is acquired, to ensure that its impact in terms of reduced capacity, limited activity and participation restriction are minimised. Thus the ICF bridges the gap between current disability policies and public health policies. In fact, the ICF provides a coherent and systematic approach to the challenge of mainstreaming. Specifically, from an ICF perspective mainstream and specialised policies and services must be considered along a continuum which is matched to the capacity and needs of the individual student.

For example, within education and training provision, the application of the ICF to the allocation of disability resources, would require a multi-faceted approach in which funding is applied to both mainstream institutions and to individuals with specific needs. The allocation of resources would be based on three different types of interventions.

1. An allocation to each school and training centre to respond to participants who are experiencing difficulties but who do not require diagnosis and to adapt infrastructure to create a more inclusive environment. These funds could be allocated on the basis of statistical estimates of the number of people within the population likely to experience difficulties.
2. Further funding could be allocated to a training centre or school based on the number of participants in the institution with documented impairments or disabilities. Once again,

funding would be provided to the school rather than linked to the individual but ring-fenced for the creation of more inclusive environments and the provision of learning supports.

3. In addition to these two funding allocations, a provision should be available to allocate resources to an individual on the basis of an individual assessment of needs where mainstream resources have proved insufficient over time to prevent a development of moderate participation restriction.

Along side this phased and targeted approach to resource allocation within the mainstream education and training systems, public health and social security resources can also be balanced between prevention, early identification and early intervention services which are focused upon the general population and specialised accommodations and supports which are targeted at people experiencing disadvantage as a result of a disability.

### **Assessing disability and allocating resources**

The appropriateness and suitability of the ICF as a frame for assessing disability and eligibility for supports and services needs to be judged in broad terms and particularly in terms of whether a bio-psychosocial approach be adopted to assessing disability and planning interventions. If the answer to this question is positive, the most well developed and relevant biopsychosocial framework in existence is the ICF.

#### Minority and deficit approaches to determining disability

Historically, there have been two other approaches adopted. The first of these is the medical/classificatory approach in which systems of provision for people with disability operate on the basis of disability categories or diagnosis. This approach is familiar to most people with an interest in the field of disability. It has many advantages including administrative convenience and simplicity in operational and financial systems. The approach is based on the premise that the diagnostic category to which a person has been designated can be used as the key to the type and level of education required<sup>23</sup>.

This approach is most often in evidence in systems where distinctions are made between different types of disabilities in funding and developing services. It is also associated most strongly with a specialized/segregated approach to delivery. There are a number of sub-optimal consequences of the application of this approach:



- One characteristic of this approach is that a person needs to attract a medical diagnosis in order to be eligible for services.
- A second characteristic is that services are developed for people within a narrow band of eligibility.
- A third element is that organisations that deliver services define themselves in terms to specific diagnoses i.e. general learning disability, autism, cerebral palsy etc. A corollary of this is that when the statutory authorities are allocating funds they do so on the basis of disability categories i.e. physical, sensory, learning disabilities and the resources go directly to the service providers rather than to the person or the family.
- A fourth characteristic is that services are designed not so much around the needs of the individual but rather around the stereotyped requirements of a particular diagnostic category.

The implications of these types of approaches for the person, his or her family and professionals working in the field are substantial:

1. The system dichotomizes people into those who are in the diagnostic net and those who are not. This means that someone with borderline eligibility is denied resources until his or her condition deteriorates sufficiently to meet the criteria.
2. Those who are assessed as eligible are assigned a diagnostic label which brings into play the negative consequences of Stigma associated with disability.
3. People with dual diagnosis find it very difficult to get appropriate services as they fall between 'two stools'.
4. People with disabilities and the parents of children with disabilities are forced to seek a diagnosis in order to get services.
5. Psychologists and other allied health professionals end up acting as 'gatekeepers' of resources as assessments focus on eligibility rather than upon needs and strengths.
6. The approach tends to support and to proliferate stereotypes of disability rather than treating each learner as an individual.

#### The inclusive society approach to disability

An alternative view of disability places it in the external environment and highlights the role that attitudes, systems and services (or the lack of them) play in creating disability. The main argument put forward for this view of disability is that if we treat people differently and educate them in a parallel system, they will develop differently and never fully integrate into the mainstream of society and society will always view them as different and stigmatized.

This approach places responsibility for the creation of disability on the very institutions originally set up to respond to disability. For example, placing a young learner in a segregated educational environment ultimately means that he or she will not learn to assimilate into the mainstream, will acquire a label and a stigma, while at the same time the resources required to achieve mainstreaming are 'locked up' in the specialised segregated system. From this perspective, it is those who assign a diagnosis that create disability.

From this standpoint the role of disability services needs to be radically changed and its primary goal refocused on creating mainstream educational, social, work and community environments in which individual differences arising from a health condition or functional impairment do not disadvantage any citizen. The approach emphasises equality of outcomes, full participation in mainstream services and contexts, independence and reasonable accommodation. The implications of this approach to disability is that resources need to be targeted at changing how disability is dealt with in the mainstream through training mainstream professionals and adapting buildings and challenging attitudes rather than maintaining the specialised system which is seen as the origin of much of the isolation and exclusion experienced by people with developmental disabilities.

This can be most clearly seen in the inclusive education approach<sup>24</sup> which requires education systems to change and respond to the learner with special educational needs rather expecting the learners to adapt to the education system. However, there is significant concern that the concept of inclusive education will be used to disestablish the special education sector without properly resourcing the mainstream.

The inclusive education movement has developed over the past 15 years in parallel with the dissemination of the social model of disability to the point where the underpinning concepts and principles have been generally accepted in most developed economies. The dilemma is no longer about whether a deficit or an inclusive approach is the right choice for special education but how it is possible to move from a position where most systems are now deficit based to where they need to be in order to meet the ideals of the inclusive society aspiration.

#### Determining eligibility and documenting needs

One key issue in this evolution is how the limited resources available to disability services can be targeted effectively at those who most need supports and interventions. Within a system structured on the basis of the deficit model, eligibility for resources is based on a recognized

diagnosis and professionals act as 'gatekeepers' to resources by ensuring that all those who are given access to resources meet the eligibility criteria.

It is more problematic within a system based on an inclusive community model. Firstly, resources need to be targeted at adapting the mainstream system rather than at individuals with disabilities. Secondly, the inclusive approach is anathema to labeling learners and so it necessary to construct an alternative means of providing services to those who need them most. However, in most jurisdictions, competent authorities still allocate budgets on the basis of disability categories/ labels. Thirdly, the limited resources available within the system for disability initiatives and programmes would be completely absorbed if they were all allocated to making mainstream infrastructure accessible and this would only address the needs of that minority of people with disabilities with mobility impairments.

One mechanism that has been used in a number of jurisdictions for allocating and coordinating services is Individual Planning or Person Centered Planning.<sup>25 26</sup> In this regard the Individual Educational Plan (IEP)<sup>27</sup> is probably one of the most well developed. This operates on basis of a Statement of Need rather than on a diagnostic label alone to allocate resources. Thus, someone with a general learning disability is provided with a Statement of Need which specifies the support and interventions required (either mainstream or specialised as appropriate) and on this basis an IEP is developed through a multi-disciplinary process which responds to the educational, social and health care needs of the individual. It is important that the statement of need has a statutory basis so that any resource specified in the statement has a legal mandate to be provided. One critical aspect of such a system is that the statutory body responsible for identifying needs is independent of the authority responsible for providing the resources.

The Statement and IEP system can operate alongside the development of the mainstream system through the adaptation of infrastructure and the training and continuous professional development of mainstream actors and professionals..

#### The need for a bio-psychosocial approach to documenting disability in society

The effective operation of a system based on individual assessment of needs and individual planning depends on the adoption of an appropriate model of disability. If the systems is based on a deficit model then the assessment of needs will focus solely on the functional limitations of the person and the only needs included in the statement will refer to interventions to build the capacity of the individual. If the system is based on a more social model, the focus will be on changes to the environment and the provision of supports to assist the learner in the mainstream

setting. Either of these approaches will result in an unbalanced individual plan. It is essential that both functional and activity limitations and environmental barriers are addressed in the statement of needs and hence in the individual plan.

In order to carry out a comprehensive assessment of need it is essential that it be based on a holistic model of human development. In effect, such a model is at the core of the biopsychosocial conception of human development<sup>28</sup>. The application of the biopsychosocial model to document profiles of functioning and disability of people is strongly recommended by many international experts in the use of the ICF.<sup>29 30</sup>

### **The ICF as a framework for documenting individual needs**

Once the argument in favour of a biopsychosocial approach to the development of a national disability strategy has been accepted, the remaining issue is which conceptual framework best reflects the principles and values of the biopsychosocial model and can provide a systematic means of documenting and responding to both individual and environmental needs and strengths. From this perspective there is no framework more appropriate and relevant than the International Classification of Functioning Health and Disability (ICF).

The ICF possesses a number of characteristics that make it an ideal framework to support the development and implementation of a comprehensive assessment of needs process.<sup>31</sup>

1. The ICF construes Disability as ***'a dynamic interaction between the person and contextual factors'***<sup>32 33</sup> as opposed to the static dichotomous characterisations inherent in the deficit and social models. In this regard it is ideal as a basis for identifying individual needs and strengths and the barriers and facilitators the person's environment.
2. The ICF is an integral part of a system of classification that includes the International Classification of Disease. Thus primary and secondary diagnoses can easily be incorporated into the assessment using a combination of ICF and ICD 10.
3. The ICF provides a systematic way of documenting not only an individual's functional capacity but also his or her limitations in carrying out activities. This is crucial given that people with the same functional impairments can differ significantly in the extent they can deal with day to day life activities such as self care or communicating.
4. The ICF provides an equally systematic means of documenting the extent to which an individual's environment is assisting him or her to perform above or below her capacity. For example, the ICF allows an assessment team to document the case where a learner is communicating more effectively as a result of an assistive device than would have

- been possible given his or her level of functioning. Similarly, the ICF allows a team to specify the extent to which the attitudes of a person's family are acting as a facilitator or a barrier to participation in mainstream education.
5. The language of the ICF is neutral unlike the terminology associated with many deficit based classification systems. In this regard it is more acceptable to parents and learners and easier to understand by teachers.
  6. The qualifier system of the ICF allows an assessment team not simply to specify the degree of strengths, needs, barriers and facilitators but also to indicate those which are amenable to change either by the provision of capacity building interventions, providing supports or by changing the environment.
  7. The ICF reflects a number of other important characteristics which make it an ideal framework for reviewing and assessing individual needs and strengths.
    - a. The ICF has been designed so that it can be used to systematically describe *Human Functioning* in general and not merely *Disability*.
    - b. It is based on a *Universal* model of functioning and activity and rather than a *Minority* model.
    - c. It is *Integrative* in that it incorporates not merely medical aspects but also psychological and social elements of the disability process.
    - d. It describes an *Interactive* process in which the relationship between function, activity and participation are not linear progressive but are amenable to change.
    - e. It incorporates the concept of *Parity* in that a functional impairment that arises from an accident or developmental process is treated the same regardless of etiological causality.
    - f. It is *context - inclusive* and does not ascribe impairment or disability to the person alone.
    - g. It has applicability in a *culturally diverse* society because the concepts which it incorporates are not particularly based on western ideology.
    - h. It is designed as an *operational* tool for policy development, research and clinical applications it is not simply theory driven.
    - i. It is designed to be relevant to the *life span*. It is not solely adult driven and thus can be used to capture developmental differences.

One of the primary aims of the ICF is to provide a scientific basis for the consequences of health conditions. One of the well documented consequences of having a health condition as a child is that it very often disrupts participation in education. The ICF has the flexibility and power to

document the educational consequences of a health condition in terms that are highly amenable to planning remedial and compensatory supports and interventions.

#### The development of the ICF Children and Youth version

One of the main drawbacks to the widespread application of the ICF in the field of special education has been the lack of a child version of the framework. This was particularly problematic because the adult version could not cater for the differences in the nature and type of functioning of children compared to adults. It is not acceptable to conceptualize a child as a smaller version of an adult. Children are in a constant process of flux, change and progressions through development. In fact in most norm based assessment tools for children it is necessary to produce separate norms for every six months of age e.g. reading, IQ etc.. It is also the case that children and adolescents are very often and appropriately restricted by their environments in their participation in many major life activities e.g. drinking alcohol or gaining admission to nightclubs. The types of participation and environments are very different for younger people.

These differences were well recognized by the WHO which requested in 2002 that the ICF be adapted for universal use in health, education and social sectors for children and youth. As result a working group carried out the work between 2002 and 2004 and field trials took place in 2005 and 2006. The applicability of the ICF-CY<sup>34</sup> was examined using four age-group questionnaires; infancy (0-2), early childhood (3-6), middle childhood (7-12) and adolescence (13-18). As a result the ICF version for children and youth (ICF-CY) was published by WHO this year. The ICF-CY is intended to facilitate continuity in documenting functioning, activity, participation and the role of the environment across the transitions that human beings make from childhood to adulthood and to facilitate communication between professionals and between service providers and parents.

The ICF-CY has the potential to overcome some of the challenges currently facing assessment and intervention in special education. Firstly, given its structure it can highlight functional differences between children with the same diagnosis. Secondly, it can emphasise functional similarities between children with different diagnoses. Thirdly, it can bridge the chasm between assessment and intervention. Fourthly, it can be used to document changes as a result of interventions not only in the performance of the child but also in the child's environment<sup>35</sup>.

The main modifications to the adult version of the ICF were:<sup>36</sup>

- a. Modifying or expanding descriptions of existing codes
- b. Assigning new content to unused codes

- c. Modifying inclusion and exclusion criteria of existing codes
- d. Expanding the qualifier system to include developmental aspects.

Basically, the ICF-CY is consistent with the organisation and structure of the adult version, expanded to cover the essential aspects of functioning and environment of childhood and adolescence. Some 237 changes have been made to ICF codes particularly in the area of activities and participation. For example, code *d1200* – mouthing, touching, smelling, tasting captures a particular developmental stage as do the codes *d1330-d1332* which cover acquiring single words or meaningful sounds, combining words into phrases and acquiring syntax.<sup>37</sup>

A manual has been developed by the National Institute of Special Needs Education in Japan for the use of the ICF-CY which has been approved by the WHO.

### **Summary and Conclusions**

The ICF is now widely used internationally in a number of policy fields including health, social care, employment, social security and education. The clinical application of the ICF in terms of assessing needs, evaluating progress and planning interventions has been well accepted in most jurisdictions at this point in time. The research applications of the ICF in terms of measuring outcomes and the impact of environmental factors on activity limitations and societal participation have been widely acclaimed. It has been used in social policy development to plan social security systems and redesign disability legislation and policy. It is also widely used statistically to collect and report data in population surveys or in administrative databases for managing systems of provision. With the publication of the ICF-CY it has lifespan relevance and can be used within education as a framework for assessing functioning and activity, monitoring progress and planning interventions.

The ICF can be recommended as a policy framework from two perspectives. On the one hand, incorporating the ICF into the conceptual and strategic framework of a National Disability Strategy can help to avoid some of the limitations associated with a number of previous approaches to disability policy which have been limited in scope, ambiguous in focus, fragmented in implementation, difficult to disseminate and impossible monitor in terms of impact. On the other hand, it provides an integrated and coherent approach to policy which is capable of capturing the dynamic and complex nature of disability, characterising its social construction, balancing specialised and mainstream initiatives and programmes, specifying cross-cutting and 'joined up' responses, supporting early intervention, setting measurable targets and measuring its impact in terms of the lived experience of citizens with disabilities and their families and carers.

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