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Integration of Mentally Disabled Individuals in the Slovak Republic: Vision and Reality

The so-called Velvet Revolution brought about decisive changes in all areas of society, including its approach to individuals with disabilities. However, indications of changes in the treatment of disabled people can be found even before November 1989, as some experts had launched a more intensive professional debate with their foreign colleagues from outside of the so-called Eastern zone. After 1990, the integration of disabled individuals into society became one of the main goals not only for professionals and NGOs, but more importantly, for the disabled people themselves.

The SR issued a public directive supporting the integration process in such a way as to enable disabled children and adults to take full part in the everyday life of the society. It is natural that the integration process focused primarily on elementary schools, which should have been the first institutions to admit children with special assistance needs into “normal” classes. After more than 20 years, it is possible to review the advantages and drawbacks connected with the integration process and furthermore, to find other areas for the development of disabled individuals and to remove barriers that divide people in the society into the non-disabled and the disabled.

My attention is drawn to mentally disabled individuals not only due to personal experience with such, but also due to the fact that this group of individuals in the SR faces the greatest obstacles in the integration process. The probable cause of this state may be the fact that mental disability often occurs in combination with other forms of disability, which increases not only the demands for their assistance, but also multiplies the distrust of the non-disabled portion of the society, caused by the shortage of information.

Indicated Problems with Integration of Mentally Disabled Individuals in the SR

Handicapped people have always been a coherent component of each human society. The concern of the majority within this specific minority varies depending on the specific time and location. Despite many differences, it is essentially possible to outline two major groups: the first which accepts these people's need for care and provides such care, and the second favouring the segregational approach. It is an established fact that people often oppose what they do not understand and are not familiar with. It is precisely the lack of knowledge which was responsible for the rejection, or, sometimes even hostile attitude of the majority towards disabled people in the past. The history of this peculiar relationship amounts to thousands of years. A more significant change occurred as late as in the second half of the 20th century, when not only the disabled themselves, but also the relatives and professionals who shared their troubles, started to fight against the oppressive treatment of disabled people.

The era of the 1990s, which in the SR was associated with immense socio-political changes, marked in our society the **integration process** which goal was to fully integrate disabled individuals into the everyday life of the society. During this period, the majority of the mentally disabled lived in social

care institutions, which were operating year-round and existed in two types, i.e. as institutions for children and youth, and institutions for adults. While the institutions for children and youth had a co-educational character, the institutions for adults were strictly segregated. As a natural consequence of this situation a **proposal** originated from the Ministry of Labour, Social Affairs and Family to replace the high-capacity institutions with sheltered flats and small-capacity institutions. It was also assumed that the newly established family-support services would persuade some families to take care of their disabled family members at home. The “return” to their natural environment was planned for all, even for those who suffered from a medium or high degree of disability.

The integration process ultimately took more than 10 years, and despite its mostly positive impact, it was also accompanied by some negative effects.

1. A nationwide organisation, which comprised the separate organisations focusing on individual disabilities, was disintegrated, and replaced by organisations that were, however, much weaker in advancing their interests.

2. The primary position was taken over by an association for disabled individuals.

3. The mentally disabled individuals who had not been publicly active by that time were often referred to as individuals without any handicaps.

4. Division between the handicapped and the mentally disabled often occurred in the rhetoric of most organisations.

These occurrences hindered the integration process of disabled people. It should be mentioned that among other causes influencing the integration process was the public opinion often mistaking mental disability for various psychic diagnoses. This opinion was to some extent also affected by the fact that most institutions were located on the outskirts of towns or out of city limits and had the character of enclosed, total institu-

tions. The intact (non-disabled) part of the population was in very scarce contact with mentally disabled individuals. The fact that employees who worked in the institutions were most often not experts in the field of mental disability also affected the integration process.

Specialists were employed in the institutions in Bratislava, Levoča, Lučenec and in several other towns. Apart from these towns, the employees forming the pedagogical (or educational) staff were educated on the secondary school level. University education in the fields of psychopedy and etopedy was a rarity in the institutions of social care for mentally disabled children and individuals. Such staff were virtually nonexistent in the institutions for adults at the beginning of the 1990s (Levická, 2000).

University training of future experts before the 1990s had been provided only by the departments of special pedagogy, or by the department of psychopedy. Contentwise, such education was focused on the preparation of teachers- and educators-to-be, i.e. mainly staff of pedagogical activities. This trend was also reinforced by the perception of mentally disabled as “eternal children”, which led to the infantilisation of mentally disabled adults, who, however, corresponded with other definitions of mental disability. Mental retardation was deemed a form of disruption in the ontogenetic development of the individual, characterised by negative deviations from the standards in the levels of intellectual and learning capabilities and in social development. Mental retardation is a state of interrupted, delayed or incomplete development of the intellect, which is characterised by below-average intelligence.

Causes and Symptoms of Mental Disability

In connection with the effort to define mental disability in literature we are often confronted with the opinion that mental disability can be considered as such only in those cases

diagnosed in early infancy, most commonly before the age of 6. This age is connected with the child's mandatory entrance into school, and thus signifies the child's first involvement in a group environment, hence the child is expected to be able to fulfil tasks related to his or her education. However, some authors are of the opinion that mental retardation can be diagnosed among some individuals all the way up to the 18th year of age, or sometimes even later, due to a gradual decline of one's abilities.

Bajo and Vašek (1994) claim that at younger age it is more appropriate to speak of some form of juvenile dementia or of retardation caused by the child's surroundings (*social retardation*). The understanding of mental retardation as a disease was definitively rejected in the second half of the 20th century, simultaneously rejecting any attempts at treating mentally disabled individuals. Since then, attention has been focused on the possibilities of personality development through adequate pedagogical activity.

The causes of mental disability include:

- Defects in the structure or function of genetic apparatus.
- The impacts of teratogenic influences damaging the evolution of the foetus during pregnancy, i.e. physical, chemical and biological causes of damage during the prenatal period including damage caused to the foetus as a result of complicated birth due to insufficient oxygen intake and other similar causes.
- Postnatal brain damage, which consequently results in impairment in the development of cognitive abilities (CNS damage, meningitis).
- Socially caused mental retardation.

Based on the causes of damage, it is possible to diagnose more types, forms and degrees of mental disability. The need to identify the cause of damage is important mainly in order

to provide assistance to parents immediately after the child's birth, to provide them with an appropriate form of intervention, and in the earliest phase to correctly set up the individual's development process (Šándorová, 2010; Smith, 1993). Proper diagnosis is possible only in an interdisciplinary team, which is capable of assessing all details. As far as the quality of the mentally disabled individual's life is concerned, an early intervention is of extraordinary importance as early practice and exercise prepare the individual for the development of practical and social skills, which turn out to be pivotal in later life.

While other forms of disability welcome immediate intervention right after birth, in the case of mental disability, intervention is usually postponed to a later period due to the fact that in some cases mental disability cannot be properly diagnosed until the age of 2 or 3, or later. In the past, the infants' situation was hindered by the fact that the diagnostic itself was superficial, which did not enable the experts to focus in their work on the areas, which can be developed well or on the areas, which require immediate development and cannot be developed after certain age.

It is therefore advantageous that the diagnostics of mental disability underwent important changes, which engendered more direct forms and means of intervention. Currently, we are confronted with multiple syndromes in this form of disability, which are considered consequences of specific genetic defects, caused either by a change in the number of chromosomes, by the disruption of the chromosome structure, or by a gene mutation. Specialists working with mentally disabled individuals should be well informed about the most frequently occurring syndromes connected with mental retardation.

The following table provides the basic information on causes and symptoms of the damage associated with selected syn-

Table No. 1. Syndromes connected with Mental Retardation (source: Author)

Title	Cause of damage	Symptoms
Down syndrome	Trisomy of chromosome 21	Stocky build, Asian facial features, wide hands with short fingers, smaller head, flat back of head, common occurrence of cardiovascular diseases, epilepsy, speech impediments, mental retardation occurring to various degrees
Angelman syndrome (also known as <i>happy puppet syndrome</i>)	Chromosome 15 defect	Stiff, ponderous walk, speech absence – minimal verbal expression – excessive laughter, epileptic seizures, concentration disorders, mental retardation
Cri du Chat syndrome (<i>Lejeune's syndrome</i>)	Chromosome 5 defect	Severe to profound mental retardation, microcephaly, poor growth, poor motor skills, congenital heart disease, frequently occurring self-injury
De Lange syndrome	Gene mutation	Moderate to severe mental retardation, diffuse muscular hypertrophy, microcephaly, frequent occurrence of compulsive behaviour, self-injury, destructive behaviour, non-verbal communication
DiGeorge syndrome	Deletion of a small piece of chromosome on the long arm of one of the pair of chromosomes 22	Mental retardation, heart defects, large vein defects, face abnormalities, e.g. cleft lip or palate
Edwards syndrome	Trisomy of chromosome 18	Small, abnormally shaped head, small mouth and nose, low set ears, malformations of internal organs, respiratory problems, mental retardation, Majority die in early age
Lesh-Nyhan syndrome	Deficiency or non-functionality of HGPRT enzyme caused by mutation of X chromosome	Hereditary disease, passed on most frequently from the mother to the son, Moderate mental retardation, uncontrolled movements, spasticity, self-injury, encephalopathy
Patau syndrome	Chromosomal abnormality – superfluous chromosome 13	Microcephaly, holoprosencephaly, small eyes, sometimes even missing, cleft lip or palate, spine defects, severe anomaly of internal organs, hearing defects, these individuals tend to live about 2 months
Klinefelter syndrome	Chromosomal aneuploidy	Mental retardation, fertility disorders, mental disability may not occur in female type (known as Turner syndrome)
Prader-Willi syndrome	Chromosome 15 defect	Short stature, hypotonia, CNS defects, mental retardation, often severe, problems with emotionality and sociability, insatiable appetite and resulting obesity, insufficient development of sexual organs, psychiatric defects, sleep apnea

Sotos syndrome	Gene mutation	Growth defects – gigantism, body asymmetry – symptoms reduced with aging, mild mental retardation, behavioural, learning and attention problems, hyperactivity, epilepsy, congenital heart disease or kidney disease may also occur
Williams syndrome	Chromosome 7 deletion	Wide forehead, protuberant cheekbones, large mouth, shallow eye sockets, delayed psychomotoric development, mental retardation of all degrees, attention disorders, hyperactivity, good hearing and positive attitude to music
Trisomy of chromosome X	Chromosome variation	Light mental retardation, manifested almost as psychosocial disturbances, decreased fertility
Bourneville-Prigle syndrome (<i>tuberous sclerosis</i>)	Chromosome 9 or 16 anomaly	Benign tumours and lesions of brain, small red tumours in the face, bright spots on the skin, hyperactivity, frequent occurrence of epilepsy
Syndrome of fragile chromosome X	Fragility of X chromosome	All degrees of mental retardation, big head, elongated face, large ears, defects manifesting in the autistic spectrum but without problems in social interaction
Smit-Magenis syndrome	Deletion of chromosome 17	Mild mental retardation, behavioural problems, hyperactivity bordering on aggression, self-injury, delayed speech development, sleep disturbances

The most frequent symptoms of mental retardation are:

- Impaired ability of abstraction, difficulty understanding and conceiving of abstract terms.
- Impaired logical thinking, judgement ability, the basis of which is forming relations between objects.
- Impaired ability of assessing level of importance, understanding arguments and counter-arguments.
- Difficulty dealing with new situations.
- Impossibility of understanding more complicated phrases.
- Impaired logical memory, which can be replaced by good mechanical memory.

Mental retardation does not occur only within the area of intellectual ability but affects the whole of personality development. Some authors (Bajo, Vašek, 1994; Požár, 2007; Valenta et al., 2012) state that mentally disabled individuals are un-

able to understand higher ethical terms and therefore do not experience emotions connected with gratefulness, responsibility or shame. Based on my personal experience with these individuals, I dare to oppose the aforementioned claim. Mentally disabled people can experience gratefulness or shame and can take their responsibility very seriously. It must be admitted that problems identifying these emotional states may occur in people with low to moderate degrees of mental retardation and in individuals with a severe degree of mental retardation. I also need to emphasise that we have difficulties identifying the emotions of these clients because we find it difficult to understand them correctly. With respect to the development in this area, it is possible to envision that we will overcome this difficulty in the future or at least diminish it.

Despite the spectrum of its expressions, it is always possible to identify two basic characteristics of mental disability:

- Considerably under-average intelligence.
- Decreased ability to adapt (Ward, 1993).

It is necessary to realise while working with mentally disabled individuals that the consequences of below-average intellect are manifested in reality as *weakened ability to concentrate, impaired short-term memory, learning difficulties and difficulties understanding abstract thoughts or more complex mental processes*. The decreased ability to adapt is generally manifested as the impossibility of adapting to some or all social norms (Ward, 1993). The impairment of the following abilities and skills were identified in clients with mental disability: *communication skills, self-sufficiency, sociability, manual skills, reading and counting skills, ability to work and the general ability and initiative of making use of opportunities and living an independent life* (Ward, 1993; Bajo, Vašek, 1994; Valenta et al., 2012). The area affected by mental disability is quite wide. It is, nevertheless, important to remember that not all problems will occur and that a mentally disabled individual

may also possess some highly developed skills (Górnicka, 2004; Ainsworth, Baker, 2004).

A correct and early diagnosis is of paramount importance for the full integration of mentally disabled individuals as it enables planning and utilising effective ways and forms of social intervention by means of which the disabled can be assisted in the best possible way. The integration itself is, however, a result of co-operation between disabled individuals and the intact part of the society. The first experience with integrating disabled individuals has facilitated to comprehend this complicated social process, and therefore, unlike other countries in the EU, Slovakia had emphasised an inclusive approach in the field of working with disabled people even before the end of the millennium. In this respect, integration is understood as part of an inclusive effort, which in practice means that experts' attention is focused on all three elements affecting this process: *the people with disabilities, specialists in various fields, and the public.*

Ways of Preventing Exclusion of Mentally Disabled Individuals

The emphasis in the 1970s on having good results in primary school did not generate positive effects exclusively. One of the less publicly discussed consequences of this phenomenon was the relegation of handicapped children into special pre-schools and primary schools. As a result, the degree of disability required for such relegation decreased and legislation was implemented for more severely disabled children to be completely exempted from mandatory school attendance, hence the education of these individuals was discontinued. Disabled children and young people were placed in special schools despite the fact that the level of their disability did not prevent them from being educated along with other children.

180 In the 1980s special schools for the disabled were attended

by children whose intelligence only slightly diverged from the norm. These children could have been incorporated into normal schools without much trouble. Furthermore, at that time, parents of mentally disabled children were advised to place their children in year-round assistance facilities. Despite the fact that a portion of mentally disabled children lived at home and were educated in special schools, the gap between the intact part of the population and the mentally disabled was widening. Stigmatisation of mentally disabled individuals in the society was on the rise. Mentally disabled people were perceived as useless, incapable of living independent lives and as a burden on society. Experts working with children and young people pointed out that these people are endowed with talents and should not be judged merely by their IQ performance (Górnicka, 2004), which should only serve the purpose of making a basic diagnosis and can never capture the true aspects of the disabled person's personality. The focus on determining the IQ of mentally disabled people hinder finding the hidden potential of their personalities and also contributes to the social exclusion of these people.

The same opinion is held by AAIDD (American Association on Intellectual and Developmental Disabilities), who came to the conclusion at their conference in 2002 that mental disability should be understood as an insufficiency characterised by significant limitations in intellectual abilities and adaptive behaviour. The AAIDD stresses that the limitations concern mainly the adaptive skills in conceptual, practical and social intelligence and may occur separately (e.g. inability of conceptual thinking), or in combination. Mental disability is referred to as a unique state of existence, which begins in childhood, is multidimensional and can be ameliorated through individual approach or support (<http://aaidd.org/>).

AAIDD distinguishes between three types of intelligence, **conceptual, practical and social**, a distinction which is

tremendously important for diagnostic purposes and for subsequent work with mentally disabled individuals. Conceptual intelligence is assessed by IQ tests. Practical intelligence is defined as the ability to take care of and support oneself as an independent person capable of performing everyday activities in one's everyday life. Social intelligence is related to the ability to understand other people's expectations of one's own behaviour in given surroundings and the knowledge required to maintain the expected behaviour in given social situations and social interactions.

The AAIDD recommendation that specialists should focus on determining the **level of required support** in connection with mental disability appears interesting from the perspective of social work (<http://aaid.org/>). The following groups reflect the level of engagement with the client:

- **Occasional** – support of episodic frequency, the individual demands short-term support, such as in dramatic life situations (e.g. loss of job, acute health problem and other).
- **Limited** – this form exceeds the extent of “occasional” support, yet it is limited by time; it may be, for example, assistance in the search for a job or in arranging independent living.
- **Extensive** – a form of continuous support which can be provided on a daily basis and may concern certain actions, or surroundings, in which the individual finds himself; not limited by time.
- **Total** – lifelong support characterised by high intensity of involvement; the individual demands assistance and support in all kinds of surroundings and in various activities; this type of assistance is demanding both materially and from the perspective of staff involvement.

I have been continually engaged in the issue of quality of life of the mentally disabled in Slovakia since 1993 and based on the results acquired in various research projects I have to

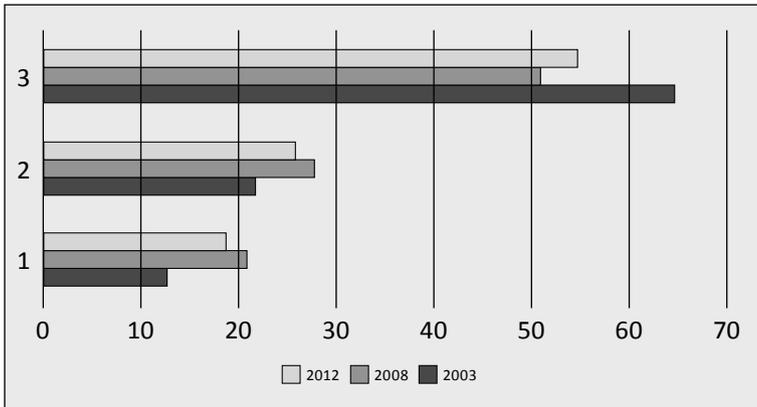
state that society's attitude towards people with mental disability cannot be considered satisfactory. This is the status quo in spite of increasing pressure since the 1990s concerning the mentally disabled as competent members of society who should be supported and assisted (Mišová, 2008; Švarcová, 2006). Nevertheless, this opinion is not accepted in its entirety even by experts. Research carried out in 2011 confirmed that some of the staff members assisting mentally disabled people hold negative opinions about them. Shockingly, some social workers employed in institutions providing social services commented on their clients in the following ways: *aberrant people who should be deprived of legal capacity, such blockheads – why, they do not even know what they would like to eat, and they should have all the rights? This only complicates our lives...* (SP-C/13), and *it would be easier to deprive them of all their rights, so that they could be easily made to sign whatever is necessary...* (SP-D/12).

The social workers, above all, should be the ones expected to defend the rights of clients in these institutions. Their opinions cannot be justified even by the fact that they were voiced by female social workers, who are granted an exception in the level of obtained education. The directors of institutions in which these social workers were employed argued that it was impossible to recruit qualified staff due to the fact that the salaries were too low within social services. Nevertheless, it must be stressed that such institutions are rather scarce and that most of the facilities providing social services have been manifesting impressive improvement in the quality of care. The employees in institutions providing social services have influence on the local politics of autonomous areas. On this level, their opinions are considered common. Yet, how can we expect understanding and acceptance from the non-disabled part of the society if a part of the involved experts hold such opinions?

An effort to change the segregational behaviour of society towards mentally disabled people was also much more inefficient compared with other forms of disability due to the fact that these clients had not been prepared to protect or defend their rights at that time. The mentally disabled were not even aware of them. Some parents who should have defended their children's interests did not even consider the status of mentally disabled people as problematic. Compared to other countries' experience, in the 1990s only a small percentage of parents and relatives of mentally disabled individuals in Slovakia got involved in the effort to improve their standing. Furthermore, those who attempted to further the cause lacked the necessary arguments.

Social workers, hand-in-hand with teachers, psychologists and other specialists attempted (and still attempt) to obtain the most relevant facts to improve the quality of life of disabled individuals. The researched facts include a listed public opinions on some circumstances of the life of mentally disabled people due to the fact that the intact portion of the population creates the conditions (mainly the legislative ones) which enable or prevent mentally disabled people from fulfilling their subjective aims. Paradoxically then, the false opinions, or disapproving attitudes of the intact population, seriously influence the accomplishment of the *vision of the most universal inclusion of mentally disabled individuals in society*. Unlike the healthy population, three main spheres determine the quality of life of disabled people, namely: **work, accommodation and family or stable romantic relationship**.

Contrary to that of the intact society, the decisive role in fulfilling the aims in this field is played by individuals who are not directly affected by the issue of mental disability. The following graphs trace the development of opinions on the studied issue within the Slovakian public in the years 2003,

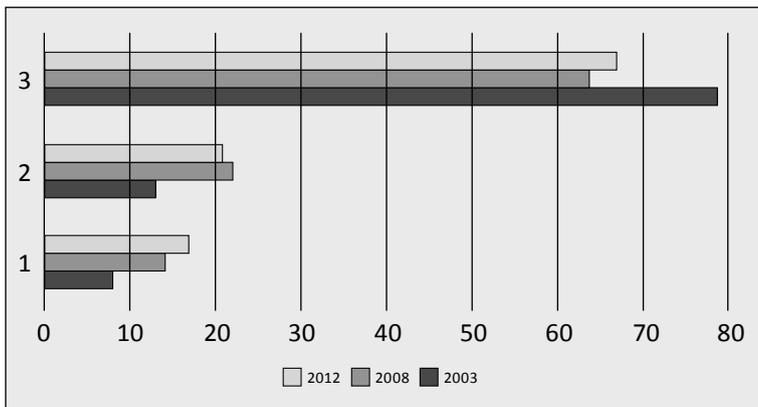
Graph No. 1: Employment of mentally disabled people (source: Author)

The 1990s witnessed various campaigns which were aimed at providing information about the lives of mentally disabled people to the public. Despite the fact that disabled people, including the mentally disabled, started to appear more often in public, in 2003 **only 13%** of respondents agreed with the statement that mentally disabled people should have equal rights to work as healthy people and should therefore be given the chance to hold a job appropriate to their skills and abilities. **Almost 65% of people rejected it.** We can witness a decrease in such disapproving attitudes in the following years all the way to 2008 followed by an increase in 2012. It must be remembered that potential employers of mentally disabled are precisely these “healthy” members of the society. However, due to the fact that almost 65% of the interviewed people do not agree with employing disabled people, our clients have to face far more serious difficulties than their healthy peers.

We can observe a similar trend in the development of opinions on the construction of sheltered housing, which would help the mentally disabled adults to become independent. The construction of such projects depends on the financial support from state budgets. Accommodation of this type for visually

and hearing impaired people and physically disabled people had been developed in Slovakia even before 1990. Nevertheless, the public attitudes in Slovakia towards sheltered housing for disabled are unequivocally negative. As may be observed in the following graph, almost 79% of the interviewed denied this option in 2003 and after a steady improvement in 2008 (64%) an increase in negative opinions in 2012 was marked when more **than 67% of the interviewed disapproved** of the construction of sheltered housing.

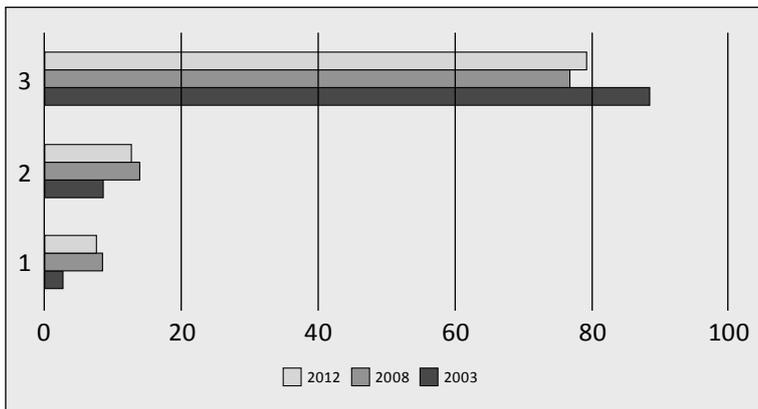
Graph No. 2: Sheltered Housing (source: Author)



The most touchy issue concerns the question of whether mentally disabled people should have the opportunity to live in stable partner relationships and form families. **Almost 88% of interviewed disapproved of this possibility.** In spite of a notable increase in positive attitudes in the recent years (77% in 2008 and 79% in 2012), those who disagree with mentally disabled people entering into marriage or living in stable partner relationships represent almost 80% of respondents. The most common argument against such possibility was that mentally disabled people are not capable of leading an independent life and therefore require long-term assistance

and support. The second most common argument put forth the concern that mentally disabled partners would have children with similar disability and their lower intelligence might lead to an inability to control their reproduction behaviour which would encumber the state's social system even more due to the fact that these parents would not be capable of raising their children on their own.

Graph No. 3: Entering a romantic relationship (source: Author)



The abovementioned facts prove that despite a broad-based inclusive political effort of all the disabled people, including the mentally disabled, the social climate is not very favourable. The vision of inclusion of mentally disabled into social life collides with the public misconception about who *mentally disabled people in fact are, what they can do and what they require in their life*.

The integration process in the 1990s focused mainly on the change in the approaches of experts working with such part of the society. In the context of defence and fulfilment of these people's human rights, we endeavoured to reach a change in perception of mentally disabled people so that doctors, psychologists and other specialists would not perceive

them as people with insufficient IQ, but rather as individuals with various skills, who can sing, draw, dance, create various objects and so on.

People with mental disability, mainly children and youth have been participating in various social activities, in which they endeavoured to draw attention to their existence and persuade the intact part of the society of the need to take interest in them. Today, we can state that the Slovakian society has become accustomed to people with mental disability. It has, nevertheless, also become accustomed to the fact that the majority of disabled people is sentenced to live their lives in institutions which are designed exclusively for them. In spite of the possibility to attend regular schools, mentally disabled students still attend special schools. Special education in Slovakia is a self-enclosed system, disconnected from regular vocational education and therefore does not offer preparation for less intellectually demanding jobs. Despite the current employment situation in Slovakia with the unemployment rate ca 13%, the graduates of special schools are automatically dismissed as undesirable in the workforce. Their employment options are narrowed down to sheltered workshops, which are, however, a rarity in Slovakia. Therefore, socialisation of mentally disabled adult population takes place in specialised institutions, or, better, in day care centres or long-term institutions for the mentally disabled, of segregatory character. Men are separated from women and their lives can be hardly compared to the lives of the common population.

Paradoxically, despite the fact that majority of disabled adult population is comprised of individuals with a slight degree of disability, public opinions on autonomy and sovereignty of mentally disabled at large are based on information about individuals with moderate to severe degree of mental disability. As already mentioned, this information may not always be reliable nor reflecting the reality. Hundreds of slightly mentally retarded

individuals, who have gone through the education process, are well-prepared to enter the open job market as manual labourers. A continuing decrease in the number of these positions is, however problematic.

Based on the surveys carried out repeatedly since 1993 I assert that the overall perception on the life of mentally disabled people which predominates in the Slovakian society might be summarised in the following way: *mentally disabled people fall behind in cognitive, speech, motoric and social skills, moreover they have adaptability problems and are not capable of logical or creative thinking. Disability also brings behavioural, social and emotional problems which are manifested by an inability to behave adequately in public and by frequent displays of aggression. Even those, who were brought up outside of institutional care, require life-long assistance and support. These individuals are not capable of leading an independent life. They are not capable of finding and keeping a job on the open job market, of managing their life and therefore need other people to decide on matters concerning their personal lives.*

This opinion is in stark contrast to the reality which has witnessed a total participation of slightly disabled graduates of special schools in the society. Many of them have a stable job and even more have families. I shall refer again to the AAIDD division of mental disability into *conceptual, practical, social and mental retardation*. If restrictions apply only to conceptual retardation, it should not prevent absolute integration of these individuals. It is a fact that well-integrated individuals with slight mental disability who do not display the practical and social aspects of their disability, **are not perceived by their surroundings as disabled at all**. Regarding the inclusive efforts abroad we can encounter the **good practice** method, which focuses on the summary of positive experience with integrating mentally disabled people in the social life. Such examples serve the purpose of demonstrating the life possibilities of disabled

individuals. This method is seldom applied in Slovakian society and only as a complementary tool to influence the public or for fundraising purposes. The **case management** method, which is according to Ballew and Mink (1996, in: Levická et al., 2012) a process, which helps people in situations in which solution requires the cooperation of several assisting professions is applied equally rarely. The above understanding of case management suggests that it is a method which is based on the mutual trust of different experts and simultaneously requires good coordination and communication skills from the case manager. It is precisely through coordination of professional activities of various experts that one can reach much better results than in the case of separately provided services. Case management is also a method which demands discussions with various people and mutual planning of a suitable intervention in the presence of the client. The mentally disabled individual becomes, in the fullest sense of the word, a partner with those who offer and provide the services for him. The experience confirms that slightly retarded individuals are successfully capable of accepting this partner role. In the context of institutional care in Slovakia, emphasis has been placed on **social rehabilitation** in the last ten years, which was defined by WHO as *a complex and coordinated utilisation of medical, social, educational and employment means to train the individual in the most effective way in order to enable one to integrate or re-integrate oneself in the society. By social integration we mean one's active participation in the work process, education or other activities associated with social and public life, but also the development of contacts and activities in one's private life* (Levická, 2005, p. 3). The basic principles comprise the rule of *orientation on preserving client's sovereignty and supporting his competences* and also the principle of *orientation on the client's social image*. With an increasing influence of ecosocial theories, which emphasise search for inspiration for work with these clients

within natural manner of human conduct (Levická et al., 2012), these principles create conditions for overcoming problematic areas in the work with mentally disabled individuals with an integrated and interdisciplinary approach.

Integration of mentally disabled people in various areas of social life depends not only on the work with the public opinion but also on work with the mentally disabled themselves. In this respect the most daring challenge is to change the approach of employees of social care institutions, most of whom still work with adult clients utilising the methods devised for elementary schools. Although these activities enable the preservation of various skills, they do not compel the clients to activities, which we may define as work. The fact that a lot of people are sentenced to life in isolated societies (usually male or female), does not imply that we respect these people as adults, but rather implies our fears from their adulthood. Preserving the current protective sheltered approach to mentally disabled individuals paradoxically becomes one of the barriers to the integration process itself.

The aims to integrate mentally disabled in the social life which were set at the beginning of 1990s cannot be considered accomplished. In spite of this it is important to stress that many positive changes in this area would not have happened was it not for this endeavour. Due to the effort to improve mentally disabled people's lives which started 20 years ago serious qualitative changes took place also in permanent institutions providing social services. Currently, I find it necessary for the Slovakian Republic to re-evaluate its aims within the issue of mentally disabled people's inclusion in the society and to set more specific objectives regarding the relation between the public and individuals with different degrees of mental disability. ■