

Historical response to disability national situations social work essay



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In the 20th century, disability was thought to be a problem inherent in the individuals. It is commonly known as the 'medical model', where disability was seen as being something 'wrong' with a person, which could be 'cured' or at least contained. The Immigration Restriction Act 1899 included in its list of prohibited immigrants any idiot or insane person, as well as those suffering from contagious diseases. Support for disabled people was expected to be met by their families. Any financial support was usually small and temporary, and was given by charitable organisations, not the tax payer. Institutions offering support for orphans, unmarried mothers and destitute. Older people began to be set up from the 1860s. From 1854, institutions were established for people with experience of mental illness. The Lunatics Ordinance 1846 provided for the safe custody and prevention of offences by persons dangerously insane, and for the care and maintenance of persons of unsound mind. These people were initially housed in jails and later in designated institutions. The eugenics movement became popular in the 19th century. Eugenics applied the ideas of biological natural selection to people (also known as 'racial fitness'). Towards the end of the 19th century, people with intellectual disabilities began to be admitted to institutions previously reserved for people with mental illness. Men and women were strictly kept apart, so they could not have children. The first school for deaf children in New Zealand opened in 1880 (now the Van Asch Deaf Education Centre in Christchurch). In the past many people died at an early age. Changing medical knowledge and technology now enables many people with ill health or physical impairments to live longer. This is the one reason that why there are more disabled people today than there was in early New Zealand. Trends in treatments change over time. Treatments for ill health once in favour may

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now be considered backward. New Zealand's population mix has changed significantly since 1840. Throughout the 19th century, young male adults made up most of our population. Today our gender balance is even and we have an ageing population. Coming out of the 19th century, there was a negative stigma attached to people with impairments. They were thought to be weaker and less valuable members of society.. Attitudes changed with the impact of disease epidemics (such as tuberculosis and polio) and injuries from World War I. Suddenly, there were people with an impairment who were otherwise young, fit and healthy. Their impairment had not been caused by a physical or moral weakness inherent in a person's genetic makeup.

Incorporate Strategies

New Zealand Disability Strategy provides a framework that will enable the government to begin removing the barriers that prevent disabled people from participating fully in society. It sits alongside other government policies like the New Zealand Health Strategy and the Positive Ageing Strategy. The Disability Strategy was developed in partnership with disabled people and their organisations. There are 15 objectives of the strategy.(a)Encourage and educate the community and society to understand, respect and support disabled people(b)Ensure disabled people's rights are understood and promoted.(c)Provide the best education for disabled people(d)Provide opportunities in employment and make sure disabled people have an adequate income(e)Strengthen the leadership of disabled people(f)Make sure government organisations, and organisations that get money from the Government, know about and respond to disabled people(g)Have services for disabled people that work for disabled people and are easy to get(h)Support

disabled people to have a good life in the community and to have the opportunity to live in their own homes(i)Support disabled people to have choices and help them to have access to recreation and cultural opportunities(j)Collect information about disabled people to help with planning and understanding what disabled people want and need(k)Promote the involvement of disabled Maori so that their culture is understood and recognised(l)Promote involvement of disabled Pacific peoples so that their cultures are understood and recognised(m)Help disabled children and young people to have good lives that prepare them to be adults(n)Assist disabled women to improve their lives and be a part of their communities(o)Recognise the importance of families, whanau and people who provide support for disabled people

Incorporate policies

The disability policy is about removing the barriers that prevent people with impairments participating fully in society. This ensures that people with impairments have access to quality education, essential services and suitable employment. It also ensures that people with impairments are safe from discrimination and have support to maintain their autonomy. Our disability policy is about removing the barriers that prevent people with impairments participating fully in society.(a)It ensures that New Zealanders with impairments have access to quality education, essential services, and suitable employment.(b)It ensures that people with impairments can participate fully in our democracy and in decisions affecting them, are safe from discrimination, and have support to maintain their autonomy.

Key principles

(a)The people living with impairments have:(b)Access to education in an appropriate form.(c) Access to and information on citizen rights and are involved in decision-making affecting them.(d) Services those are responsive, flexible, assessable and culturally appropriate.(e) Barriers to their active participation in society removed.

Incorporate funding

(a)Services need to be funded in a way that encourages providers to provide higher quality care to more people for each dollar spent. The National Health Board has been tasked with changing the funding of national services to meet these objectives and to encourage DHBs to be more innovative in the application of their allocated funding at regional and district levels.(b)The following approach will be used when selecting a funding mechanism for a national service:(c)Services currently centrally purchased through a Ministry of Health NDE output class will continue with existing arrangements until a decision is subsequently made on its appropriate location(d)If the service is currently funded by DHBs from their allocations, and the Minister determines (on the advice of the National Health Board) that there is likely to be a long-term need for central planning, the National Health Board may take over responsibility for both planning and funding the service. In this case the National Health Board will work with DHBs(e)If the service is currently funded by DHBs from their allocations, and the Minister determines (on the advice of the National Health Board) that there is likely to be a short-term need for central planning (e. g. for less than three years), the National Health Board may consider taking over responsibility only for planning the service, with it

continuing to be funded by DHBs, through an agreed mechanism.(f)The elements of the proposed funding system for DHBs are:(g)Funding will continue to be allocated to all DHBs using the Population-based Funding Formula. DHBs will use this funding to provide or purchase services for their populations. The way in which each DHB will pay its share of the costs of a collaborative service and the way in which they will collectively pay the provider of the service will be negotiated as part of the regional plan. For example, some regions may move from a fee-for-service basis to bulk funding arrangements. In other cases, where it is beneficial to do so, they may elect to use the Inter-District Flow framework.(h)The National Health Board will play an important support role in helping DHBs to identify appropriate funding methods and price structures and levels, particularly through the provision of relevant costing information and economic advice.

Service provision

District Health Boards (DHB)

(a)Auckland DHB primarily provides services to people living in the Western Bays, Hobson, Eastern Bays, Balmoral, Avondale/Roskill, Penrose and Hauraki Gulf Islands area of Auckland City. It also provides a range of specialised services referred to as tertiary services available to people living outside this area. These include specialised neurological services and services for children at Starship Hospital. Auckland DHB is contracted by the Ministry of Health to provide a national information service called Residential Care Line.(b)Disability Services purchases disability support services from Auckland DHB for all eligible people living in the Northern DHB regions.

These include rehabilitation services provided by Rehab Plus, a specialist

post-acute rehabilitation facility for adults aged 16 to 64 years, and complex wheelchair and seating assessment provided by Mobility Solutions.

(c) Disability support services for people under 65 years are provided by the Ministry of Health Disability Services. Services for people 65 years and older are provided by District Health Boards. There are 21 District Health Boards in New Zealand and they are responsible for the provision of health and disability services for the population residing in the DHB catchment area.

The District Health Boards are supported by the Ministry of Health, which provides national policy advice, regulation, funding, and monitoring of their performance. (d) Disability support services funding for older people (aged 65

or over and those people aged 50 to 64 assessed as "close in interest" to those aged 65 years and over who require access to disability support services) was devolved from the Ministry of Health to DHBs on 1 October

2003. (e) The devolution of disability support services for older people aimed to support a DHB to meet the Health of Older People Strategy (HOPS) by bringing the planning of health and disability services together. A DHB now has funding responsibility for the following services: (f) Assessment,

Treatment and Rehabilitation (A T & R) (g) Needs Assessment and Service

Coordination (NASC) (h) Aged residential care (i) Home based support

services (j) Carer support and respite care (k) Disability Information and

Advisory Services (l) The Health and Disability Commissioner is an

independent agency that supports and protects the rights of consumers who use health and disability services.

Access framework

(a)The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are the New Zealand Public Health and Disability Act 2000, the Health Act 1956, and the Crown Entities Act 2004.

1. New Zealand Public Health and Disability Act 2000

The NZPHD Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes district health boards (DHBs), and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations. The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include to improve health and disability outcomes for all New Zealanders, to reduce disparities by improving the health of Maori and other population groups, to provide a community voice in personal health, public health, and disability support services and to facilitate access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.

2. Health and disability strategies

The Minister of Health is responsible for strategies that provide a framework for the system and for reporting on their implementation to Parliament. (In the case of the New Zealand Disability Strategy, this responsibility is shared with the Minister for Disability Issues.)Four key strategies currently in place are the:(a)New Zealand Health Strategy(b)New Zealand Disability

Strategy(c)He Korowai Oranga: Māori Health Strategy(d)Primary Health Care Strategy.

3. Health Act 1956

The Health Act sets out the roles and responsibilities of individuals to safeguard public health, including the Minister of Health, the Director of Public Health, and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies, and the national cervical screening programme.

4. Crown Entities Act 2004

Many of the organisations that provide health services are Crown Entities. The Crown Entities Act provides the fundamental statutory framework for the establishment, governance, and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their board members, responsible Ministers, and the House of Representatives.

Terminology

Language reflects the social context in which it is developed and used. It therefore reflects the values and attitudes of that context and plays an important role in reinforcing values. Take care with the language you use when talking with or about people with impairments. Most disabilities are not a disease so a person with disability should not be called a "patient" unless being referred to a hospital setting. In an occupational and physical therapy context, "client" or "customer" is preferred. Avoid using "deformed," "deformity" and birth defect as a person may be "born without arms" or has a

" congenital disability," but may not be probably defective. Say " person with Down Syndrome." Avoid " Mongol" or Mongoloid." Avoid saying " mentally retarded", " insane", " slow learner", " learning disabled" and brain damaged." Say " person with an intellectual disability", or " person with a psychiatric disability." Avoid saying " cerebral palsied" and " spastic". Say " person with cerebral palsy". Say " person with epilepsy" or " child with a seizure disorder". Avoid using the word " epileptic", either as a noun or an adjective. Words are important, so it is necessary that our words do not offend or reinforce negative stereotypes. Always measure how you interact with people with impairments in the context of their disability. Do not ridicule someone because of impairment - this is oppressive behaviour and should not be tolerated. At the same time, an attitude that is patronising or shows fake enthusiasm is also demeaning. Focus on the person's individuality, rather than the impairment.

Attitude

Disabled people say that people's attitudes and behaviours can be as big a barrier to participating in society as physical barriers can be. Promotion greater understanding of disability, and disabled people's desire to live a life on an equal basis with others, is a key action in the New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities. The Human Rights Act 1993 makes it illegal to discriminate against people on the basis of disability, but clearly this treatment is continuing. New Zealand's Disability Strategy (NZDS), introduced in 2001, is a laudable attempt to remove barriers to participation, but it can never force a change of attitudes. Attitudes towards people with disabilities can influence many

aspects of their lives, including their self esteem, how they are treated by the society and public policy and service provision.

Barrier

Exclusion is felt by people with disabilities as they rarely interact with the society. People with disabilities feel they are left behind and ignored as the society learns and moves at a faster pace. Communication is a main barrier towards disabled people. People with learning difficulties may find speech difficult, or are afraid to communicate in society, especially if they have had bad experiences of being called names or subjected to humiliation in the past. People with mobility problems also feel isolated as a result of their disability. Some people are not sure as how to approach a person with disability as they may be unsure of their disability. Barrier is there if there are no standards of physical accessibility, access to public facilities and buildings. Disabled people have lesser qualifications than the non disabled people hence, there is a barrier as they are unable to get jobs which leads to them being unemployed usually. Lack of information and knowledge can also be a barrier that can make them inactive and therefore, they would be hesitant to step forward outside with the community.

Stereotypes

People often tend to focus on the impairment of a person or the limitations caused by it as opposed to the varied qualities and attributes the person may have. Before we look at how we can interact positively with people with impairments, we need to be aware of common stereotypes and see how damaging they can be. Disabled people are sometimes defined as less

intelligent and cannot do regular tasks, are lazy and making it up if disability
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is not visible. It is also a fact that some employers do not hire people with disabilities since they believe they are not capable of doing the job. They are seen as unable and some are abused especially those with mental problems.