The community participation services social work essay

Disability has been thought as a limitation or a problem inherent in the individuals until the late 20th century. This is so-called medical model of disability. Under this theory, disability was seeing as being something wrong with the person. However, those attitudes have changed radically. For the most parts, these movements reflect changing attitudes overseas, in a similar way to the other social policy change. Solutions to the problem of disability took the form of government and wider society helping to fix or accommodate the problems of those afflicted individuals in New Zealand.

2) Themes of change

The following historical overview and timeline comes from two sources: a 1996 article by Margaret Tennant in the New Zealand Journal of Disability Studies, and a 1997 National Health Committee Report. Increased survival: In the past many people died at an early age. Developing medication and technology now enables many people with physical impairments or ill health to live longer. This is one reason why there are more disabled people today than there was in early New Zealand. Medicalisation of disabled people: With the increase in medical treatments possible, especially after World War II, people's impairments were seen as treatable in the same way that ill health was treated. This approach focused attention on the impairment of disabled people rather than their wellbeing. As a result, the individual, ordinary life needs of people were often not taken into account. Trends of best practice: Trends in treatments change over time. Treatments for ill health once in favour may now be considered backward. For example, isolation of people with intellectual disabilities in institutions was once the standard - this practice is not considered now, with

the emphasis instead on supporting people to live in their communities. Demographic changes: 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. Perceptions of stigma: 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. A moral distinction had emerged between people who deserved support - those impaired by accident or illness - and people born with impairment. Attitudes changed with the impact of disease epidemics (such as tuberculosis and polio) and injuries from World War I. Suddenly, there were people with 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. Support organisations: As organisations focused on specific impairments and support for families grew, so awareness of disabled people and the number of services available increased – such as, the Association of the Friends of the Blind in 1889, the forerunner of the Royal NZ Foundation of the Blind in 1890, CCS in 1935 and IHC in 1949.

3) The Strategy

The New Zealand Disability Strategy presents a long-term plan for changing New Zealand from a disabling to an inclusive society. It has been developed in consultation with disabled people and the wider disability sector, and reflects many individuals' experiences of disability. Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other

impairments. Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have. Along with other people, disabled people want a good life. However, they also face huge barriers to achieving the life that so many take for granted. These barriers are created when we build a society that takes no account of the impairments other people have. Our society is built in a way that assumes we can all see signs, read directions, hear announcements, reach buttons, have the strength to open heavy doors and have stable moods and perceptions.

4) Funding

Community Participation services

The Ministry of Social Development governs the Very High Needs School Leavers programme which supplies person targeted funding for vocational services for school leavers classified while at school under the Ongoing and Resource scheme as having very high educational needs. The funding is mostly used to pay for Community Participation services.

Day services

The Ministry of Health(MOH) has a historic practice of funding day services in some regions. In those regions, MOH funds people who are unable to get supported by the Ministry of Social Development. Generally, MOH funds the full service. In some of cases, MOH tops up funding when a Ministry of Social Development funded community participation service is not able to provide enough support for a person with high needs. MOH funded day services are

mainly for people aged under 65. However they continue to be funded for existing clients once they turn 65, unless the person no longer wants the service or is assessed as requiring age-related residential care. The following table summarises the different funding arrangements (these figures are rounded):

Ministry

MSD

MSD

MOH

Service type
Community ParticipationVery high needs school leaversDay Services

Number in service
10, 0005902, 200

Age & disability
people with all types of impairmentage 16-65people with all types of impairmentage 16-65people with physical, sensory and intellectual disabilities. no age limit for people who accessed day services before age 65

Funding model
partial fundingbulk-fund servicesproviders determine accesscapped fundingspecified amountfunds individuals who meet eligibility criteriademand drivenfull fundingfunds providers for individuals who meet eligibility criteriacapped funding

Total funding

$42 million p a$10 million p a$40. 3 million p a

2. 2

1) Terminology

Language reflects the social circumstance in which it is built up and used. Therefore, it mirrors the values and attitudes of the society, and plays an important role in reinforcing values and attitudes that lead to discrimination and isolation of particular people. Language can be used as a powerful tool to facilitate change and bring about new values, attitudes and social combination. Here are a few examples of the preferred terminology. Deaf-mute / Dumb - people who consider themselves as part of Deaf culture refer to themselves as " Deaf" with a capital D. Because their culture derives from their language, they may be identified in the same way as other cultural groups. Mongol / mongoloid - use " person with Down syndrome." Mentally retarded / insane / learning disabled / brain damaged - use " person with an intellectual disability" or " person with a psychiatric disability". Suffers from / afflicted with - " Suffers from" shows ongoing pain and torment, which is no more the case for most disabled people as it is for most people without disabilities. " Afflicted with" designates a disease, which most disabilities are not. Victim of - it means that a crime is committed on the person who has a disability. Cerebral palsied / spastic - use " person with cerebral palsy". Epileptic - use " person with epilepsy" or " child with a seizure disorder". Midget / dwarf - Some people prefer to use little or short, but the best one is " person of short stature". Handicap - The word " handicap" comes from the phrase " cap in hand", referring to a beggar, and is despised by most people

with disabilities. Avoid using " wheelchair-bound" or " confined to a wheelchair". People see their wheelchairs as a convenient transportation, not prisons, and the " bound or confined" expression belies the fact that many people with motor disabilities engage in activities without their wheelchairs, including driving and sleeping. The better expression is " uses a wheelchair". Most disabilities are not a disease. Avoid calling person with a disability " a patient" unless referring to a hospital setting. In an occupational and physical therapy context, " client" or " customer" is appropriate. Some diseases by legal definition are considered disabilities. Victimization imagery (" AIDS victims") or describing the person by the disease (" she is a diabetic") is inappropriate. Use the expression " person with diabetes" or " people living with AIDS".

2) Attitudes

One in five people in New Zealand reports having a long-term impairment. Because everyone comes from different backgrounds, has different beliefs and has different needs, there is a great diversity of people who have impairments. Attitudes have been recognised as the primary barrier that operates at all levels of person's life in the general population. Attitudes and ignorance make disabled people felt as stigma, prejudice and discrimination. In the year to June 1999, disability discrimination took up the largest category of complaints to the Human Rights Commission. Stigma, prejudice and discrimination are involved in our behaviours. Sometimes the combination of attitudes and behaviours seem to create almost insuperable barriers, for example, whole systems or organisations can become a barrier much in the way that institutionalised racism operates.

3) Stereotypes and Barriers

For children with disability and their families/whanau, their needs can put big demands, including financial pressure. It is hard for disabled people to get a job. For example, the unemployment rate for people with ongoing mental illness is very high. Half of recent complaints to the Human Rights Commission in regard to disability related to employment. Despite equal employment opportunity policies, the public service hires a far lower proportion of disabled people than exist in the general working age population. Disabled people often do not have many housing options through poverty or factors such as discrimination when neighbours object to supported houses being established in their area. Although New Zealand has strong standards for physical accessibility, access to public facilities and other buildings such as marae is poor. On top of that, most public transport is not independently accessible, and car modifications are expensive. Disabled people do not have enough opportunities for the educational conditions than non-disabled people. People in higher level of the society are more likely to access and receive support services than people in low socio-economic areas. Maori and Pacific people are typically low users of support services. 44% of Maori with a long-term impairment report that they have an unmet need for some kind of service or assistance. 29% of non-Maori with a long-term impairment report an unmet need. The majority of support for everyday activities comes from families. Poor literacy becomes a cause of communication barriers. This problem extends to Braille and sign language literacy. Disabled people, especially those with psychiatric or intellectual impairments, are often shut out of social networks and full participation in community activities because people are ignorant or fearful of behaviour

they see as different. As a group, disabled people are likely to have lower incomes and fewer financial and family resources than the general population. This economic disadvantage is compounded by the financial cost of disability. The earning potential of families with disabled children can be reduced by their need to provide support for their children or live and work in areas where they can access family or professional support.

2. 3

1) Disability Support Service (DSS)

Within a decade, New Zealand's DSS system has been changed from one that had a substantial institutional component in 1990 (particularly for people with intellectual disability) to one that is now almost entirely community-based. Habilitation is a concept similar to rehabilitation, except that it applies to gaining function, health, skills, and experiences for the first time, as opposed to recovering something that has been lost. For example, people who are born with physical impairments often need physio and occupational therapies to gain movement that develops naturally in others. People who spent their early years in institutions may never have learned basic life skills such as cooking, housekeeping and using the public transport system. Habilitation potentially includes a broad range of services designed to promote independence. Comprehensive Assessment and Service Coordination. The first step in developing a habilitative system is performing a comprehensive assessment that focuses on people's goals and coordinating habilitative services from an array of service systems. This issue applies to all DSS population groups and is addressed in Chapter 6. Skilled Therapies. Occupational, speech and language, and psychotherapies

can all be critical to promoting function and independence. Though theoretically available to people, access can be a problem, particularly for the many people who get caught between service systems. Boundary issues exist between DSS and the personal health and mental health systems, for example, which can result in significant obstacles to obtaining therapies. In primary and secondary schools, therapies are generally available only on a consultative basis to staff. Vocational Services. Many people in the DSS system have little or no employment experience and require pre-vocational and vocational services.

2) Enabling Good Lives

The Working Group suggests that the current centre-based model for day and community participation services be incrementally replaced with a facilitation-based support model. The key point of this model is assisting disabled people to achieve a ' good life' like other people in New Zealand. The heart of facilitation-based support would be on enabling disabled people to do the routines in communities, rather than on provision of special places or activities for disabled people.

3) facilitation-based support

The facilitation-based support model actively supports disabled people to have an ' everyday life in everyday places'. It would help people to achieve outcomes such as education and training, employment, socialising, having relationships and a family, taking part in community and cultural activities. Self-directed planning & facilitation: a skilled staff(facilitator) chosen by the disabled person would assist him or her to build and maintain relationships and support networks in the community, access mainstream community-

based services and activities, and classify opportunities to contribute to the community. The facilitator would help the person to identify their aspirations and goals, and build up a plan to achieve them. The level and duration of support would differ for each person. The facilitation role would be independent from both funding allocation and direct service provision (e. g. support with personal care, mobility assistance). It would be a joint agency initiative (potentially the Ministry of Health and Ministry of Social Development). There would be regular independent external evaluation to ensure that the facilitator is being responsive to the individual/families within a reasonable timeframe. Cross-government individualised/portable funding: an individual allocation of funding would be available to the disabled person, potentially on a self-directed basis. This would require all current disability support funding the person attracts to be identified, (e. g. day service, community participation, home and community support service, individualised funding, residential, supported living) and unpacked where this is possible. Strengthening families/whanau: Families/whanau would be supported to assist the disabled person by promoting family-to-family support, and family and whanau collectives. There would be separate funding support for family carers to make integrity into the system, cultivate natural supports, and distinguish the legitimate needs of the individual and family. Community building: mainstream organisations would be supported to address barriers to inclusion that disabled people face, e. g.: the built environment and attitudes of employers, government agencies etc. Most of this work would be done by the facilitator or providers who are enabling people to participate in the community. There may also be support from

general disabilities funding, specific initiatives or employing ' change agents'.

4) Transitions from school

Young disabled people who are transitioning out of school and into adult life, would make a good starting point, as they are already at a point of change in their lives. The questions that will be asked and plans for adult life that will be developed, as part of facilitation-based support, are the kind that would be asked by any young person at this point in their lives. Young disabled people in New Zealand are generally separate from older disabled people in their experiences (e. g. of mainstream schooling) and consequently their expectations are often different from those of earlier generations of disabled people. This means that young people typically have greater willingness for a support model that allows greater independence.

5) Geographic centres or regions

Implementation can begin in identified geographic regions and be expanded to other places as capacity allowed. This means different thoughts could be tested and more detailed costings recognised, and would be consistent with the approach used by the MOH's ' New Model for Disability Supports' in the Bay of Plenty. The Ministry of Health is developing a proposal for new Community Living options for disabled people currently living in residential services. There may be opportunities to check the Community Living and facilitation-based support together as the people concerned will need new arrangements for all their supports in the community.

6) Age-related service

The disabled elderly people will have varying care needs, ranging from help with household tasks to full nursing care. To assess future needs, it is necessary to evaluate the current options for care of the disabled elderly. These range from residing in the community with help from community services and family members, to institutional care. Two levels of institutional care for the elderly are available in New Zealand: geriatric hospital care and rest home care. Rest homes cater for a less disabled group.