Module 22

Role of Social Work in the Field of Disabilities

Component IA

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Component IB

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| Objectives            | ● Understand the relevance of social work practice in the field of disabilities  
                        | ● Learn about the role of a social worker |
| Key words             | Role of Social Work in Disabilities, Case Work, Group Work |
Quadrant 1

1. Introduction

Working with the persons with disabilities can be an extremely rewarding area of work which involves supporting disabled people to lead fuller, more independent lives, taking up education and employment opportunities and contributing to their communities. People who have mental or physical disabilities often face a unique set of challenges in their everyday life. The challenges individuals with disabilities face largely depends on their specific impairments as well as their severity.

This module explains the role of social work in addressing issues of persons with disabilities. At the end of this module, the student will be able to:

- Understand the relevance of social work practice in the field of disabilities
- Learn about the role of a social worker

2. Relevance of Social Work in the Field of Disabilities:

The people with disabilities and handicap have the same needs as others. They need friendship, a satisfying job, an adequate income, recreation and comfortable housing. Unfortunately the prevailing social attitude towards them is unhealthy. This stems from the stigma attached to the family with a disabled member. Some families do not have the love and patience needed for such a person. Originally a disabled person is the sole responsibility of the family. Now Government recognize their rights and make efforts to give formal and non formal education services for them. These services are provided by co-operative efforts between voluntary agencies and the ministries.

Professional social work is based on problem solving and change management. Social worker utilizes a variety of skills, techniques and activities consistent with a holistic focus on disabled individuals and their environment. The aim of social worker is to work in partnership with service users, families, carers, staff and service providers to identify needs, provide practical and emotional support and empower service users and their families to enhance their quality of life.

Social work bases its intervention on a systematic body of evidence based knowledge and practice. The primary area of Social Work intervention is therapeutic work. Different therapeutic methods can be used by social workers such as casework, meditation, counseling, group work, crisis intervention, family therapy, solution focused Brief Therapy and Bereavement Work.

Social workers work with individuals with a disability, with families who have a child or family member with a disability as well as with communities both domestically and internationally. Our work in these spheres encompasses, direct practice, group work, community development, policy practice, research and advocacy. Social workers have played key roles in the development of
antidiscrimination legislation, policies that support persons with disability and the development of disability programs. Social workers work alongside people with disabilities and families to realize social inclusion, community living, employment, family support, and rehabilitation.

Social work theory and practice in the field of disability has been greatly influenced by values and philosophy of the independent living movement. This movement has shifted practice from creation of clients dependent on service controlled by professionals to work in partnership with the disabled people to secure their rights as equal citizens of the country.

3. Social work and the meaning of disability:

The dominant view of disability in social work and social services has been the medical model, which views disability as a functional limitation, as individual ‘problem’, ‘pathology’, ‘dysfunction’, or ‘deviance’ (Brzuzy, 1997; Finkelstein, 1991). Oliver (1996) emphasized that the individual / medical model locates the “problem” of disability within the individual and considers functional limitations or psychological losses to arise naturally from the individual deficit. This view is also called the personal tragedy theory of disability, which posits that disability is a natural disadvantage suffered by disabled individuals when placed in competitive social situations. Instead of viewing disability as inextricably linked to social, cultural and political milieu, the medical or personal tragedy framework infers that the disabled individual is plagued by deficits and is in need of medical fixing (Quinn, 1995b).

Social work also addresses the issue of grief, loss and bereavement associated with mental and physical disability. Disabled individuals are commonly depicted as suffering subjects, characterized by the devastating changes and crises for both themselves and their families. Recognizing, accepting and coming to terms with the disability are viewed as the targeted outcomes of social work intervention (e.g. Hartman, Macintosh, & Engelhardt, 1983; Krausz, 1988; Parry, 1980).

Social work has also addressed disability from an ecological or psychosocial perspective. For example, Mackelprang and Hepworth (1987) suggested the importance of extending the medical perspective of disability to social factors such as stigma, architecture, and awareness of a social structure constructed by the able-bodied. Under this framework, the extent of disability is reciprocally determined by transactions between people and their environments rather than within the individual alone. Social workers have, indeed, articulated the importance of inclusion and accommodation for individuals with disabilities; however, they have largely stayed away from active involvement in the disability rights movement that has been initiated by people with disabilities and their advocates.

In recent decades, social work has moved towards empowerment, strengths, and resilience perspectives (Burack-Weiss, 1991; Saleebey, 1997). Drawing on the work of Solomon (1976), social work adopted the empowerment framework which concerns itself with the increase in the social, economic, and political influence of oppressed groups in relation to privileged sections of society (Hahn, 2005). In recent decades, the empowerment perspective has encouraged social inclusion and the rights of persons with disabilities.
workers to develop collaborations with oppressed groups such as persons of color and persons living in poverty (May, 2005); however, empowerment theory has had little impact on practice with people with disabilities who are more affected by the mainstream medical model than other vulnerable populations (Felske, 1994; Linton, 1998; Morris, 1991; Moxley, 1992; Zola, 1989). Empowerment has tended to revolve around temporary interventions that are assumed to produce lasting effects; however studies (Gillum, 1998; Hiranandani, 1999) suggest empowerment of disadvantaged groups may be relatively temporary in a hegemonic socio-political milieu of skewed power relations.

The strengths perspective assumes that strengths, such as talents, capacities, knowledge, and resources exist in all individuals and communities. With regard to disability, strengths perspective takes the view that disability is an opportunity for growth as well as a source of impairment. As such, practice with people with disabilities attempts to take into account their abilities instead of disabilities in service planning, delivery, and assessment (Raske, 2005). The resiliency model upholds the inherent strengths in individuals and families who have overcome environmental, social, and personal barriers despite oppression and discrimination (Bernard, 1991). However, the resiliency perspective poses a danger, in that people with disabilities who “overcome” their disability are seen as “disabled heroes.” While disabled heroes can be inspiring to people with disabilities and comforting to the able-bodied, they may perpetuate the false notion that anyone can “overcome” the disability and accomplish unusual feats. As Wendell (1997) pointed out, most disabled heroes have exceptional social, economic, and physical resources that most people with disabilities do not have access to. The image of the resilient disabled hero creates an ideal which most disabled people cannot achieve, thereby increasing the “otherness” of the majority of people with disabilities.

Although empowerment, strengths, and resiliency perspectives have advanced the field of social work in the direction of its core mission, yet no social work perspective to date has the transformational power to change social and individual views about disability (Raske, 2005). Raske writes none of the above perspectives “have incorporated the notion that disability must be redefined to sever its socially constructed link with functional impairment and subsequently, with discrimination” (2005, p. 99). Citing Pfeiffer (2001), Raske points out if the social system is truly flexible and fully accommodates people with disabilities, disability would disappear.

Overall, despite the positive developments in social work, the profession has done little to promote disability rights; social work literature, research, and practice on disabilities have lagged behind other topical areas dealing with oppressed groups (Gilson, Bricout, & Baskind, 1998; Mackelprang, 1993; Mackelprang & Salsgiver, 1996; May, 2005). Notwithstanding the move towards ecological, empowerment, and strengths perspective in social work, the impact of the medical model of disability is evident in policy analysis research, which is synonymous with a lack of consultation with people having disabilities, the lack of emphasis on the social and political forces impacting the lives of people with disabilities, and a reduction of disability to simplistic “objective” criteria that measure functional limitations. To the extent, disability policies rely on disability-as-individual-problem framework, they marginalize the possibility of
more enabling methods of human welfare that are based on participation, social integration, and equal citizenship (Priestley, 1999).

4. Areas of Social Work Intervention in the field of Disability

Social work practice with persons with disabilities includes the following key roles;

- Maximizes clients’ involvement in exploring an expanded range of options and choices;
- Prepares clients to be more effective in dealings with professionals, bureaucrats and agencies that often do not understand nor appreciate their need for self-determination; and at the organizing level, mobilizes and helps to empower groups of people with disabilities to consider policy and program alternatives that can improve their situation;
- Social Work bases its interventions on a systematic body of evidence based knowledge and practice. The primary area of Social Work intervention is therapeutic work. Different therapeutic methods can be used i.e. Casework, Meditation, Counselling Group Work, Crisis Intervention, Family Therapy, Solution focused Brief Therapy and Bereavement Work. Central to the role of Social Work is developing and maintaining relationships with service users and their families. Social Work involves seeking, developing and delivering appropriate services to service users and their families / carers.
- Participation in Person-Centred Plans with service users their families and other team members.
- Administration and report writing.
- Referral to and liaising with other relevant internal and external services and resources.
- Maintaining communication and networking with relevant people and services.
- Advocacy and empowerment.
- Protection and welfare work.
- Empowering people to access information / service around entitlements benefits and legislation.
- Organising / Accessing residential and family based respite schemes and a range of home support services.
- Facilitating access to Residential Care and Independent Living.

5. Other Areas of Social Work Involvement

- Identifying gaps in current provision and seeing or developing new services.
• Highlighting inequality and working to bring about change in social policy, agency policy and societal attitudes.

• Promotion of Equal Opportunities and nondiscriminatory practices.

• Developing and maintaining best practice in the field of disability in line with professional social workers association.

• Person Centered Plan enable people with a disability to direct the planning process to the greatest extent possible and make their own choices about how they wish to live their life, plan in a way that respects the needs of family members and carers and their role in the person's life, be assisted to identify goals and the way these can be achieved, explore supports that are flexible and wide-ranging and be included and fully participate in community life. Person centered Plan may assist people with a disability to continue living in the community by providing a range of supports to maintain independence, keep living in their own home, move to more independent living arrangements, learn new skills and participate in the local community.

6. Methods of social work in the field of disability

If consideration is given to the three main social work methods, it is nonetheless possible to make a number of statements relevant to practice. The switch from an individual to a social model of disability does not signify the death of casework for example. Rather it sees casework as one of a range of options for skilled intervention. It does not either deny that some people may grieve or mourn for their lost able-body but suggests that such a view should not dominate the social worker's assessment of what the problem may be. Shearer (1981) cites one such example of “a man who contacted his local social services office to seek help with getting his ceiling painted was treated instead to a lengthy visit which has to do with the need the social worker saw for him to come to terms with the fact that he had, some years ago, broken his spine.”

Thus grief work or bereavement counselling may be appropriate in some cases but not all or even a significant number. Some disabled people, particularly those suffering from progressive diseases, may need long term support of the kind that only a casework relationship can provide and building upon Alf Morris's idea of the disabled family, the whole family may indeed become the target for casework intervention.

Similarly group work need not focus solely on the need to create a therapeutic atmosphere in which individuals or families can come to terms with disability. Groups can also be used to pool information on particular benefits, knowledge on where and how to get particular services and even on a self-help basis to give individuals the confidence to assert that their disability does not stem from their physical impairments but from the way society often excludes them from everyday life. In addition the group can be used as the major means of giving disabled people back responsibility for their own lives as is described in a recent discussion on residential care (Dartington, Miller and Gwynne, 1981). “Meetings in the small residential groups were a forum for staff and residents to plan their activities and to determine priorities. They gave the opportunity for residents to take responsibility for themselves and also for the staff to do ‘social work’.”
The potential for intervention using community work methods is also exciting. There have already been a number of local access groups which focus on the way the physical environment disables people and numerous access reports and guides have been produced. A few community workers have organised 'forum' meetings of all organizations of and for disabled people in a particular locality and these have proved useful in confronting local authorities about cut-backs, in ensuring that the needs of disabled people are taken into account in pedestrianisation schemes and so on. And if the definition of 'community' is expanded beyond its strictly geographical meaning to take in the idea of moral communities (Abrams 1978) or psychic communities (Inkeles 1964) then it is possible to see community work methods being used in disability organizations. For example, the Spinal Injuries Association is currently employing a welfare officer whose job is one of enabling its members to work out their own problems and solutions by utilizing the collective wisdom and experience of its 3,000 paraplegic members through mutual support, peer counselling and the provision of information and advice.

6.1. Case work

The individual model of Disability sees the problems that disabled people experience as being directly related to that disability. The major task of the professional is therefore to adjust the individual to his own particular disability. There are two aspects of this; firstly there is physical adjustment through rehabilitation programmes designed to return the individual to as near normal a state as possible: and secondly there is psychological adjustment which helps the individual to come to terms with his physical limitations.

Disabled individuals are assumed to have undergone a significant loss and as a result depression may set in. In order to come to terms with this loss, a process of grieving or mourning will have to be worked through, in similar manner to those who must mourn or grieve for the loss of loved ones. Only when such processes have been worked through can individuals cope with death or disability. Some writers have seen these mechanisms as a series of stages or steps which have to be worked through. A recent study (Weller & Miller 1977) in New York University Hospital identified a four-stage process by which newly disabled paraplegics come to terms with their disability.

Stage 1 - Shock: the immediate reaction to the physical and psychic assault of spinal cord injury often characterized by weeping, hysteria, and occasionally psychosis with hallucinations.

Stage 2 - Denial: a refusal to accept that complete recovery will not take place.

Stage 3 - Anger: often projected towards those physically active around them, who serve as constant reminders of what has lost.

Stage 4 – Depression: a realistic and most appropriate response to a condition of a severe and permanent disability and a necessary stage if adjustment, rehabilitation and integration are to be achieved.

Because a disability often involves motor, cognitive, sensory, or mental health impairments, a psychologist may wrongly assume that a client with a disability wishes to focus primarily on the disability or its effects (Dunn & Dougherty, 2005; Dykens, 2006; Olkin, 1999b; Reeve, 2000). Although some clients with disabilities may struggle with feelings of loss or need appropriate SWE/SWFD/RSWFD/M22 by Mr. Ajeesh P Joseph
skills training, many others simply want better lives. For example, some clients might want psychological support to enhance their quality of life by resolving relationship problems, making career choices, or developing strategies to transition to their next development stage (Eklund & MacDonald, 1991).

It is increasingly recognized that people with disabilities, like everyone else, have unique strengths (Shogren, Wehmeyer, Buchanan, & Lopez, 2006). A client whose strengths are recognized and enhanced has a more positive self-image and ability to deal with life issues (Dunn & Dougherty, 2005; Dykens, 2006; Olkin, 1999b). Personal strengths include education, personality traits, creativity and talent, social relationships, and access to necessary supports. Interventions that consider the personal strengths of a client with a disability increase the individual’s self worth, empowerment, and resiliency (Dunn & Dougherty, 2005; Dykens, 2006).

The choice of intervention depends on the client’s reasons for seeking psychological services. Interventions may focus on increasing self-determination, or being empowered to make one’s own decisions and choices about life (Duvdevany, Ben-Zur & Ambar, 2002; Nota, Ferrari, Soresi, & Wehmeyer, 2007; Shogren, Wehmeyer, Reese & O'Hara, 2006). Working with a client to develop his or her self-advocacy skills promotes self-determination (Goodley & Lawthom, 2006; Olkin, 1999b; Reeve, 2000). Individuals advocating for their own social, economic and political opportunities and personal relationship needs may have a greater sense of empowerment and well being.

6.2. Group work:

The social model holds that disability is a product of the ongoing interaction between individuals and their environments (DePoy & Gilson, 2004; Gill et al., 2003; Hahn, 1999; LoBianco & Sheppard-Jones, 2007; Longmore, 1995; NIDRR, 1999; Smart, 2001; Smart & Smart, 2007). This model focuses on the dynamic interactions of their individual characteristics (e.g., conditions, functional status, personal social qualities) with the natural, built, cultural, and social environments (NIDRR, 1999). For example, a newly hired individual with a disability who uses a walker to aid mobility may face physical and attitudinal barriers to work and negotiate appropriate accommodations with the employer.

The social model illuminates how environments may impede or facilitate individual functioning by erecting or removing barriers to full participation (Linton, 1998) while emphasizing social and functional accommodations. Solutions include using universal design to create accessibility for everyone, allowing individuals with disabilities to make their own decisions, educating the public about disability issues and attitudes, and enforcing laws to ensure equal access and protection (Olkin, 1999b; Smart, 2001). In this model, a psychologist can facilitate a client’s positive disability identity and self-advocacy skills, or consult with others to ensure that the client has adequate accommodations, opportunities for participation, and a voice in decision making.

6.3. Community Based Rehabilitation Programs
At the international level, mostly on behalf of and for the disabled, instead of by them, a number of efforts are underway to help persons with disabilities become integrated in the mainstream of society. One of the major programs of the United Nations Development Programs is community based rehabilitation (CBR) guided by Einar Helander who states that "CBR is a learning process, not a blueprint or readymade solution" (Dalal, 1998).

Community Based Rehabilitation is a "strategy for enhancing the quality of life for the disabled people by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights." Community Based Rehabilitation additionally may be defined as "a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities." CBR is implemented through a joint effort between people with disabilities, their families and communities, and the appropriate health, education, vocational and social services. In the history of social services in India, no other concept has become as popular in such a short time as CBR. It began as an international movement with the growing realization that institutional services are not only considerably more costly, but additionally do not integrate people with disabilities into the societal mainstream. CBR was regarded as a new approach in which families and communities are given the responsibility for the welfare of their members with disabilities. The success of CBR lies in encouraging people with disabilities, their families, and the local community, to join in this program.

CBR is very appropriate in the Indian cultural setting, where social and community bonds are quite strong and deep-rooted. The challenge is to harness the potential of these bonds for rehabilitation related social action programs. The emerging view today is that CBR programs need to draw their resources from existing community development programs and should integrate with them.

The concept and practice of CBR has come down a long road in India. With the initial euphoria subsiding, now there is a better appreciation of the problems and prospects of CBR in action. Much experience has been gained in trying to implement this concept. This experience should help in meeting the challenges that are unique to the Indian social reality. For the success of CBR in India, it is crucial that professionals in India learn from success, as well as from failure.

Many of the voluntary and non-governmental programs that are in existence in India are organizations that have existed for a number of years and have received substantial funding and attention from within and outside the country. However, looking more closely at the programs shows several disparate factors. For example, several authors on the topic of rehabilitation programs in India have stated that many of these programs and organizations receive recognition and are funded because of their activities rather than achievements. These authors claim that a closer look at these programs show that they often are merely sets of activities without a real goal or long term viability. They are noted to be usually cost-intensive, but rarely cost-effective, which makes them continuously dependent on donors, and makes it difficult to replicate the programs, especially if the donors were to stop funding them (Thomas, 1998). In most instances,
the original program plan does not have mechanisms for determining the outcome of activities and their costs, or a system of regular monitoring and evaluation based on some quantifiable values. This anomaly exists largely because many of the programs are fund driven rather than need driven. Such programs become counterproductive to the cause of development of rehabilitation services in the long run. At the most, it supports the people associated with a program, but the program itself has little long term viability. In a few instances, it has resulted in a ridiculous situation where the professed goals of the program shift from one ideology to another according to the shift in the priorities and attitudes of the donors because the organization cannot survive without the donors' goodwill. Repeated failures of this nature reduce the confidence of consumers in the effectiveness of welfare activities.

7. Role of Social workers in the field of Disability

Most often social workers are the only members of rehabilitation teams who have the knowledge and responsibility to focus on the social life and needs of patients. Therefore it is incumbent on social workers to help the teams recognize this “new” definition of social independence and client self-determination.

It may also be necessary for social workers to more fully emphasize their role as educators in their work with patients and the teams. Social workers need to be attuned to the new realities of life with a disability which make it far less restrictive and offer consumers more life options than were available in the past. Overemphasis on dealing with fears about life with a disability, and “heroic” efforts to restore “normal” functioning are often perceived by the disability rights community as misguided. They contend that such forms of practice are based on stereotypes, on overly gloomy visions about what life with a disability will be like, or visions of life in institutionalized settings. Most of the general public is probably unaware of the many people with disabilities who are now able to live, work and shop in mainstream communities, while also forming meaningful social relationships, inspite of severe disabilities. Social workers need to become familiar with case examples and be able to communicate this perspective (or even connect patients with such individuals) so that newly impaired individuals and their families may become aware of how life can be full and rich even with the acquisition of a severe impairment. Such awareness may also lead them to reconsider the effort and attention they are asked to expend in order to achieve relatively minor gains in physical ability that may be less than worth the effort.

Another important role for social workers is helping both the rehabilitation team and the patient with the process associated with transitioning decision making power from the professionals to the patient. By the time of discharge, and ideally even before that, people with disabilities should be able to weigh and articulate their desires and preferences with regard to the various treatment options.

8. Disability Rights Perspective
Social workers may need to initiate ongoing liaisons with independent living centers and other alternative sources of information if they are to expand their knowledge to include options, resources and services that go beyond what is currently available (Zola, 1983). This suggests that there may be a role for social workers to engage in client and systems advocacy within their organizations, with third party payers and with legislators, to ensure that funding and services are available for people with disabilities. Moreover active partnerships with social workers to achieve services that promote independent living should go a long way toward ameliorating some of the resentment felt by many people with disabilities.

In light of the failure of the medical and rehabilitation establishment to even recognize these relatively new perspectives that are now embraced by the disability rights movement, some activists openly question whether professionals can be counted on for help in working toward the empowerment of people with disabilities. In their view, over the years all too many rehabilitation professionals have tended to promote dependence rather than independence (Berrol, 1979; Zola, 1979). A recent study suggests, however, that social workers may be moving somewhat closer to the aspirations and goals of disabled people (Beaulaurier & Taylor, 2000). The authors conclude based on their findings, that there may be an important role for social workers to perform as intermediaries between health services professionals and organizations and the people they seek to serve. Before social workers can do that, however, they must become educated themselves, and have their consciousness raised. Health and rehabilitation professionals may have the best of intentions and might be “dismayed” to be told that they are helping to foster “technological dependence” and that this is not supportive of disability rights movements’ goals for empowerment, self-determination and social integration at the community level.

It is important to recognize that up to now the disability rights movement has largely been a self-help movement, and sometimes it has taken on an adversarial role toward professionals whom they have not seen to be particularly supportive. It may be incumbent, therefore, for social workers to demonstrate to such groups that they have valuable skills and knowledge that can be beneficial to their purposes. Berrol suggests that professionals seeking to promote independent living and foster the empowerment of people with disabilities must provide leadership in their areas of expertise without dominance, they must provide services, they must be active advocates, they must share their unique skills, and they must provide training. They must assure that there are the same opportunities to develop positive role models as are available to the able-bodied population. (Berrol, 1979)

As social workers begin to reach out to the disability rights community the roles that may be most valuable to and appreciated are those of educator and advocate (Zola, 1983). These are not new roles for social workers. However, this does suggest that community organizing, organizational practice, case management and advocacy skills may take on heightened importance in working effectively with this population.

9. Empowering People with Disabilities

Managed care settings may well create even greater needs for social work mezzo and macro skills. Tower (1994, p. 191) has suggested that given increasing caseloads and service demands,
and decreasing social service budgets in the health services sector, client self determination may be “the first thing to go” as social workers struggle to balance their workloads. In light of the increasing activism and assertiveness of many people with disabilities this could put social workers at odds with clients and client groups. Effective social work practice with people with disabilities requires a re-focused conceptual framework that will support and promote self-determination. This framework must be designed to enable people with disabilities to expand their range of options and choices, prepare them to be more effective in dealings with professionals, bureaucrats and agencies that often do not understand nor appreciate their heightened need for self-determination and mobilize and help groups of people with disabilities to consider policy and program alternatives that can improve their situation.

Direct practice with clients with disabilities will certainly remain a primary activity of health and rehabilitation social workers with perhaps greater secondary emphasis on mezzo and macro skills. However, this practice must increasingly emphasize empowerment objectives rather than mere compliance with medically prescribed treatment plans and, or, our traditional psycho-social clinical interventions. Fostering the independence and empowerment of people with disabilities requires enabling them to become motivated and skilled at helping themselves. Independent living services, inspired by the disability rights movement, emphasize concepts that rely on preparing consumers to help themselves:

The staff’s role is to provide only what relevant training and problem solving is needed in acquiring and using services until the consumer becomes self-reliant. The move from dependence on staff to self-direction marks the shift from “client / patient mentality” to “consumer mentality” (Kailes, 1988).

Social workers can approach practice in a similar way in order to help negotiate the transitions that will enable people to move from the passive role of patient to the active role of informed and empowered consumers. Several authors have discussed and outlined approaches to advocacy practice that seem particularly useful for health social workers in their work with people with disabilities.

Gutiérrez (1990) has identified four psychological changes that are particularly important in empowering clients: (1) self efficacy - the belief that one’s actions can produce desired changes, (2) group consciousness - identification as a member of a class and recognition of how political, social and physical structures effect the class, (3) reduction of self-blame for negative consequences of being a member of the class, (4) assuming personal responsibility for change - preparing to take action to improve one’s own situation. As social workers assess their practice with people with disabilities they need to focus more on helping them accomplish these person-in-context changes.

The lack of control that many people with disabilities experience while they are in the treatment process is, however, not simply a psychological phenomenon. Social workers in health and rehabilitation settings must develop and demonstrate skills that will facilitate helping their clients...
to press for inclusion in the planning and decisions that will be made about their treatment. Social workers will also need to consider more emphasis on their practice role as educators in order to help clients become effective advocates and negotiators for their own interests. This will require that practitioners modify customary approaches to include more emphasis on dealing with organizations and systems enabling people to identify issues, to partialize the sources of their problem, and to speculate about possible solutions. The worker converses about power and conflict, encourages people to challenge preconceived notions, and works to unleash their potential (Grosser & Mondros, 1985).

Emphasis on such practice includes familiarity and skill with the advocacy and negotiation modalities that focus on dealing effectively with bureaucracies, administrative structures and centers of power that make decisions and allocate resources. In order to accomplish this, social workers may need to interact more deliberately and purposefully with practitioners engaged in both the independent living and disability rights movement. This suggests a need for more inter-organizational dialogues and agency agreements for working together to identify issues and concerns, formulate agendas and develop reciprocal understandings.

Finally, health social workers must gain increased levels of knowledge about the particular issues that are of concern to the disability community. Direct services social workers need to be responsive to issues such as the isolation and lack of group consciousness that many people with disabilities experience. These feelings often derive from limited contacts with other people with disabilities. People with recently acquired disabilities need to interact with empowered people with disabilities. Pinderhughes, writing from an ethnic minority perspective, encourages creating linkages with natural support systems such as family, church groups, fraternal and social organizations (1994). Such natural gatherings of networks of individuals who share similar characteristics and a desire for empowerment simply did not exist among people with disabilities until relatively recently.

10. Summary:

In the past quarter century however, much progress has been made by people with disabilities who are working to develop and create more functional community supports. In some communities independent living centers have been organized, developed and administered by and for people with disabilities and they often collaborate with more advocacy oriented organizations. They sponsor and produce newsletters and newspapers, electronic bulletin board services and internet news groups. Social workers need to have first hand familiarity with such functional communities in order to be able to link their clients to them. This requires more than a general awareness that such sources exist. Social workers also need to have the community liaison skills to create and maintain linkages and networks between such groups, services and their own health services organizations (Taylor, 1985; Weil & Gamble, 1995).
In this electronic text, overview about the role of social work is briefly described. In the subsequent modules detailed information’s about models of rehabilitation is provided in order to develop better sight to the learner on every aspect of disability and rehabilitation.

This electronic text is supported with electronic tutorial that consists of multimedia through use of innovative techniques and this intends to give the learner a quick and easy understanding about the lesson delivered through this module. Besides glossary of terms, web resources and bibliography relating to this e-content is provided. Self simulation for assessment and evaluation is also provided to support the effective utility of this content by the learner. This helps the learner to quickly evaluate the understanding developed by the learner regarding the contents discussed in the module. The learner is encouraged to expand on this for achieving comprehensive knowledge base on this content.

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