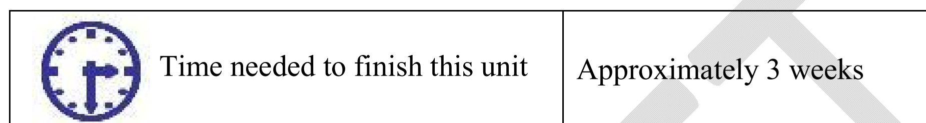
Theories of community Organization

UNIT 3

Introduction

Different community follows different regulations and norms which could be depend on the culture, tradition, religious and practice issues. Every community should get their appropriate honour as they deserve as every community is unique. So community organization theories developed by considering individual community which could be carefully handle during application of these theories.



Time needed to finish this unit	Approximately 3 weeks

Lessons of this unit
Lesson 1: Community organization theory and its implication
Lesson 2: Health promotion needs assessment
Lesson 3: Disability and health impact
Lesson 4: Psychological aspects of rehabilitation service delivery

Lesson 1: Community organization theory and its implication

Learning Objectives:

After completion of this lesson learner will be able to

- understand the community organization theory and its application.

Keywords	Community Organization theory

Subject-matter

3.1.1: Basics about community organization Theory

Theories can either be broad or abstract and pertaining to general patterns in society or describe patterns that occur in specific situations (i.e. communities, organizations, or specific population groups)

DRAFT

Historical development of community organization in the U.K is divided into 4 phases by Baldock in 1974

- **First Phase** (1880-1920): During this period the community work was mainly seen as a method of social work. It was considered as a process of helping the individuals to enhance their social adjustments. It acted as major player to co-ordinate the work of voluntary agencies.
- **Second phase** (1920-1950): This period saw the emergence of new ways of dealing with social issues and problems. The community organization was closely associated with central and state Govt.'s program for urban development. The important development in this period was its association with community association movement.
- **Third phase** (1950 onwards): it emerged as a reaction to the neighbourhood idea, which provided an ideological phase for the second phase. It was period were the professional development of social work took place. Understanding the shortcomings in the existing system, it was a period where the social workers sought for a professional identity.
- **Fourth phase**: It is the ongoing period that has marked a significant involvement of the community action. It questioned the very relationship of the community work and social work. It was thus seen as period of radical social movement and we could see the conflicts of community with authority. The association of social workers and the community are de-professionalized during this period. Thus it was during this period the conflictual strategies that were introduced in the community work.

3.1.2: Definition of community organization

UNITED NATIONS in 1955 considered community organisation as complementary to community development. United Nations assumed that community development is operative in underdeveloped communities and community organisation is operative in areas in where levels of living are relatively high and social services relatively well developed, but in where a greater degree of integration and community initiative is recognised as desirable.

MURRAY G. ROSS in 1955 defined community organisation as, A process by which community identifies its needs or objectives, orders (or ranks) these needs or objectives, develops the confidence and will to work at these needs or objectives, finds the resources (internal and/or external) to deal with these needs or objectives takes action in respect to them and in so doing extends and develops co-operative and collaborative attitudes and practices in the community.

C.F. MCNEIL in 1954 defined it as "Community organisation for social welfare is the process by which the people of community, as individual citizens or as representatives of groups, join together to determine social welfare needs, plan ways of meeting then and mobilise the necessary resource."

KRAMER and SPECHT in 1975 defined "Community organisation refers to various methods of intervention whereby a professional change agent helps a community action system composed of individuals, groups or organisations to engage in planned collective action in order to deal with special problems within the democratic system of values."

3.1.3: Models of Community organization

Jack Rothman, 1979 has introduced three basic models of community organization. There are:

- ***Locality development -*** It is a method of working with community groups. It was earlier used by the settlement houses. Here the important focus is about the process of community building. Leadership development and the education of the participants are the essential elements in the process. It aims at meeting the needs of the target population in a defined area. E.g. Neighbourhood development, Road development of a block area etc.
- ***Social planning -*** It is a method of working with a large population. The focus is in evaluating welfare needs and existing services in the area and planning a possible blue print for a more efficient delivery of services to the social problems. It is a responsive model to the needs and attitudes of the community. E.g. Housing, Health Insurance, Affordable education etc.
- ***Social Action -*** It is a strategy used by groups or sub communities or even national organisations that feel that they have inadequate power and resources to meet their needs. So they confront with the power structure using conflict as a method to solve their issues related to inequalities and deprivation. E.g. A structural systems change in social policies that brings disparities between people of different socio-economic condition in social rights like educational policies, employment policies...etc.

3.1.4. Principles of Community organization

Principles are expressions of value judgments. It is the generalized guiding rules for a sound practice. Arthur Dunham in 1958 formulated a statement of 28 principles of community organisation and grouped those under seven headings. They are:

- ❖ Democracy and social welfare;
- ❖ Community roots for community programs;

- Citizen understanding, support, and participation and professional service;
- Co-operation;
- Social Welfare Programs;
- Adequacy, distribution, and organisation of social welfare services; and
- Prevention.

In India, Siddiqui in 1997 worked out a set of principles based on the existing evidence based indigenous community organization practices are:

- *Objective* movement;
- Specific *planning;*
- Active peoples *participation;*
- *Inter-group* approach;
- *Democratic* functioning;
- Flexible *organisation;*
- Utilisation of available *resources;*
- *Cultural* orientation.

DRAFT

3.1.5. The role of theory in community practice

- Theories in community practice describe the distribution of power & resources in society, how organizations function, and how community systems maintain themselves;
- Theories must be empirically tested and verified;
- Independent and dependent variables must be identified in order to test a theory;
- Therefore theories contain assumptions about cause and effect relationships.

The "effect" aspect of cause and effect relationships are outcomes, things that occur because of specific events or actions. Consequently, they suggest specific actions or skills that can be used by social workers to produce results.

Hierarchy of role

- **General and More Specific Theories**
- **Practice Activities in Model (Intervention or Cause)**
- **Outcomes or Effects**

In social work, practice models help us use theory to define a specific set of actions or interventions that can be used to produce outcomes. Generally several theories are combined to produce practice models. We may also apply aspects of theories to certain situations.

For example, power-dependency theory tells us that resource donors acquire power by transferring money and goods to people that can't reciprocate. This suggests that nonprofit organizations should not accept funds from a single large donor if they want to be independent.

3.1.6. Different Theories of Community Organization

❖ **Systems and Ecological Theory**

The systems theory of community organization is focused on community maintenance. In this sense, maintenance refers to the establishment and reiteration of deeply held values and social norms. For example, a close-knit community might share a common belief in the importance of the family unit or of the need for safe schools. Business owners who are able to pick up on these systems or "ways of being" within the community will be better informed on marketing their products and services. Systems theory is closely related to ecological theory, which states that the organization most fit to meet the wants and needs of the community is the one most likely to survive and become profitable.

❖ **Conflict Theory and Power Dependency**

While the idea of systems theory works to a greater or lesser extent in small or tightly bound communities, today's complex and multicultural communities are often more aligned with what's called conflict theory. This community organization theory states that there is an innate competition in society between the haves and the have-nots. Power dependency is a sociological term which means that some people, and hence some businesses, will acquire more influence as a result of their economic means or earning potential.

❖ **Resource Mobilization**

While the arguably bleak picture painted by conflict theory certainly exists in many communities -- particularly those in urban locations -- another community organization theory called "resource mobilization" says that members of a community are able to join together to acquire power. This approach suggests an idea in line with Marxist theory, which states that alliances of working-class people can form to petition for better rights and working conditions. Businesses too, particularly smaller ones, are potentially able to mobilize their resources. Working with another business to share customers, for example, is one way of aligning to increase competition against an industry's bigger or more well-known players.

DRAFT

❖ **Constructivist Theory**

Constructivist theory is the use of informal knowledge to build a business's brand reputation and influence within the community. As a small-business owner, this building entails getting involved directly in the inner workings of the community in which your business operates. Sponsor a local sports team, donate some of your profits to a local charity or become the patron for a school event to market your business within the community while at the same time gaining some valuable information on how community members think, feel and respond to the products and services you offer.

Theory typology in community practice

Theory	Description
Systems Theory	Community maintenance
Ecological Theory	Survival of fittest organization
Conflict Theory	Competition between the haves and the have not
Power-dependency	Power acquired through social exchange
Resource Mobilization or Social Movement	Forming mass organizations to acquire power
Constructivist	Use of informal knowledge

Empowerment Model:

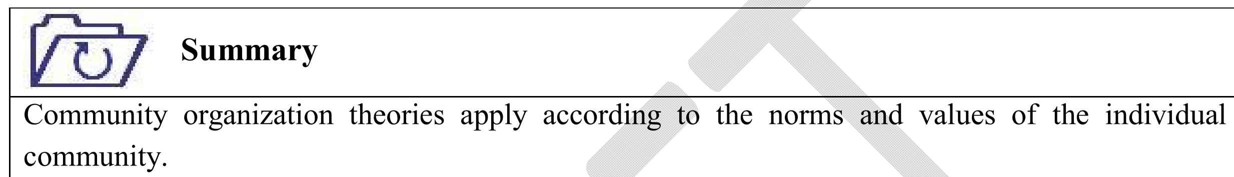
	Social Worker	**Constituent**	**Organization**
Role	Facilitator	Change Agent	Resource Provider
Practice Activity	Information Forms Self -Help Groups Leadership Training	Self-Advocacy Group Member Decision-maker Political Activist Evaluator	Brings constituents together.to take action Provides decision-making opportunities Voter registration & education
Outcomes	Worker Self- Efficacy Policy Change	New Skills Self-Efficacy Political Power	Constituents Political Power Better Service

DRAFT

Impact on Society

- Improves Informal Networks in the Community;
- Improves Linkages between individuals and institutions;
- Leads to changes in laws and institutions;
- Reduces the oppression of marginalized groups.

Learner's Activity	Practical application of theories of community organization



Summary

Community organization theories apply according to the norms and values of the individual community.

Study Skills

Short Questions

- What is community organization theory (COT)?
- What are different community organization theories?
- What are the applications of community organization theory?
- What are the social impacts of COT?

References

Hardcastle, D. & Powers, P. (2011). Community practice: Theories and skills for social workers. Oxford University Press. New York.

Barnlund, D. C. (2008). A transactional model of communication. In. C. D. Mortensen (Eds.), Communication theory (2nd ed., pp47-57). New Brunswick, New Jersey: Transaction.

Littlejohn, S.W. and Foss, K.A. (2008). Theories of human communication, 9th edition. Belmont, CA: Thomson Wadsworth.

Craig and Robert T. (1999). "Communication Theory as a Field". Communication Theory. **9** (2): 119–161.

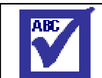
DRAFT

Lesson 2: Health Promotion Needs Assessment

Learning Objectives:

After completion of this lesson learners will be able to

- conceptualize health promotion need assessment and its application in disability management and rehabilitation.

 **Keywords**	Health promotion needs assessment

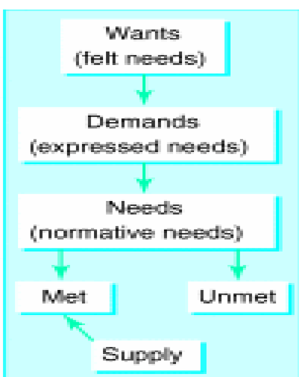
Subject-matter

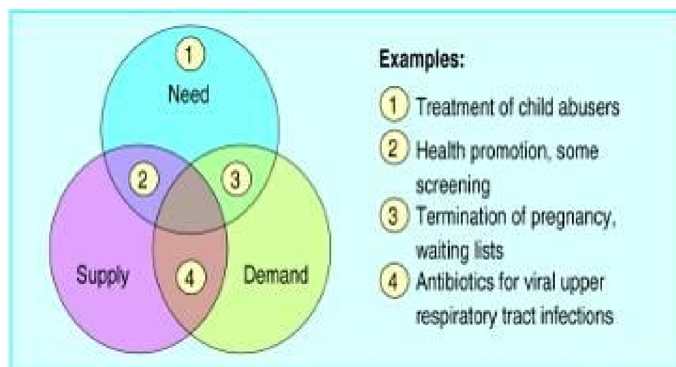
3.2.2. Health Needs Assessment (HNA)

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. Health needs assessment is a new phrase to describe the development and refinement of well-established approaches to understanding the needs of a local population. In the 19th century, the first medical officers for health were responsible for assessing the needs of their local populations. More recently, in the 1970s the Resource Allocation Working Party assessed relative health needs on the basis of standardised mortality ratios and socioeconomic deprivation in different populations, and it used this formula to recommend fairer redistribution of health service resources.

3.2.3. Needs in Health Care

Physicians, physiotherapists, occupational therapist, speech therapist, sociologists, philosophers, and economists all have different views of what needs are. In recognition of the scarcity of resources available to meet these needs, health needs are often differentiated as needs, demands, and supply.

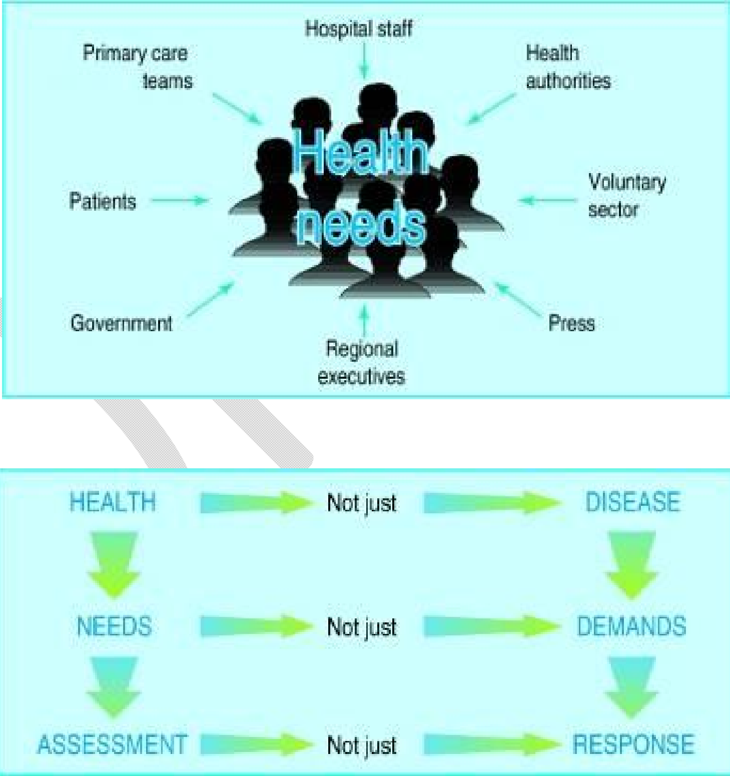




The World Health Organisation's definition of health is often used: "Health is a state of complete physical, psychological, and social wellbeing and not simply the absence of disease or infirmity." A more romantic definition would be Freud's: "Health is the ability to work and to love."

Healthcare needs are those that can benefit from health care (health education, disease prevention, diagnosis, treatment, rehabilitation, terminal care). Most doctors will consider needs in terms of healthcare services that they can supply. Patients, however, may have a different view of what would make them healthier—for example, a job, a bus route to the hospital or health centre, or decent housing.

Health needs incorporate the wider social and environmental determinants of health, such as deprivation, housing, diet, education, employment. This wider definition allows us to look beyond the confines of the medical model based on health services, to the wider influences on health (box). Health needs of a population will be constantly changing, and many will not be amenable to medical intervention.



3.2.4. Why do we undertake HNA?

- ❖ HNA is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities;

- HNA provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation;
- HNA provides an opportunity for cross-sectorial partnership working and developing creative and effective interventions.

3.2.5. What are the benefits of HNA?

Benefits from undertaking HNAs can include

- Strengthened community involvement in decision making;
- Improved team and partnership working;
- Professional development of skills and experience;
- Improved communication with other agencies and the public;
- Better use of resources.

3.2.6. What are the challenges of HNA?

- Working across professional boundaries that prevent power-or information-sharing;
- Developing a shared language between sectors;
- Obtaining commitment from 'the top';
- Accessing relevant data;
- Accessing the target population;
- Maintaining team impetus and commitment;
- Translating findings into effective action.

3.2.7. Resources required to start an HNA

- Clear aims and objectives for the project have been identified;
- There is an established need for the project (eg a recent assessment has not already been done);
- The right people are involved – this should include who knows about the issue; who cares about the issue; and who can make change happen;
- There is sign-up to the project from senior managers and policy makers;
- A lead coordinator with project management skills can be appointed;
- Access to the target population and their willingness to engage with the project has been established;
- A committed and skilled project team can be appointed (see pages 50-53 for possible skills required);

DRAFT

- ❖ Key stakeholders can be identified;
- ❖ The proposed project team has adequate resources – time, space, equipment, skills and funding – to conduct a good quality HNA.

3.2.8. The Five Steps of Health Needs Assessment

Step-I: Getting Started:

To undertake this first step, you should assemble a group of people who are interested in the project to consider the following questions. Ensure that you record your decisions for future referral, report writing and evaluation purposes. Invest some time in making sure people have a shared understanding of the common language- this will avoid a lot of potential confusion later on.

By the end of this step you should:

- ❖ Have a clear definition of the population you are going to assess;
- ❖ Have a clear rationale for the assessment and its boundaries;
- ❖ Know who needs to be involved, and how;
- ❖ Understand what resources are required, and how to keep the project on track.

Step 2: Identifying health priorities

By now you will have a working definition of the population you will be assessing, and have clarified the aim of the assessment and its boundaries. The next step is to identify the health priorities for that population.

By the end of step 2 you should have-

- ❖ Identified the aspects of health functioning and conditions and factors that might have a significant impact on the health of the profiled population;
- ❖ Developed a profile of these issues;
- ❖ Used this information to decide a limited number of overall health priorities for the population, using the first two explicit selection criteria of HNA –
    - ✓ Impact
    - ✓ They have a significant impact in terms of severity and size
    - ✓ Changeability
    - ✓ They can be changed locally.

Step-3: Assessing a health priority for action

This step is the assessment of a specific health priority for action. The health priority may have been identified from either:

DRAFT

- The profile of the important aspects of health conditions/determinant factors for your target population and agreed list of health priorities – established by working through steps 1 and 2; or;
- A national or local priority identified without population profiling or completing step 2 – eg a priority for many NHS planners is coronary heart disease, as both a national and local priority. If you are starting with a national or local priority it is crucial to ensure local ownership and involvement with that priority;

By the end of this step you should

- Identify who should be involved in making the specific change happen, and included them in the process of choosing actions to tackle this health priority;
- Gain a clear and shared understanding of the health priority through identifying the health conditions and determinant factors that have significant impacts on it;
- Gain a clear understanding of the boundaries of the assessment;
- Identify effective interventions to tackle this health priority;
- Define your target population;
- Identify the changes required;
- Confirm that the proposed changes will help reduce health inequalities.

Step-4: Action planning for change

Now you have worked out what changes you want to make in order to tackle your chosen health priority, and why, you should concentrate on how to implement change. This is the action planning for change stage of the project, and you will need to bring your team together to agree a plan.

By the end of this step you should have

- agree a clear set of aims, objectives, indicators and targets;
- set out the actions and tasks you need to undertake to achieve these;
- agree how you will evaluate your programme;
- identify the key risks to the success of the programme and how they will be managed;

Step-5: Moving on/project review

This final stage of the HNA process involves the team in some reflective questions and the opportunity to take stock and learn, both for individual contributors and from a team perspective. This is a vital part of the process if HNA is to continue to be a relevant and effective tool in improving health and tackling health inequalities in the population.

DRAFT

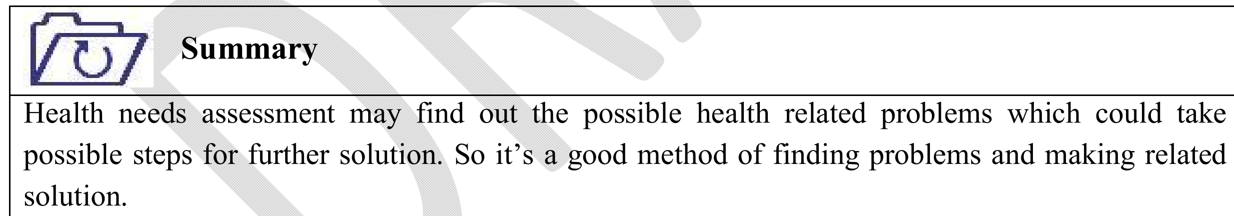
Learn from the project

- ❖ What went well, and why? Check achievements against the original aims and objectives of the project;
- ❖ What did not go well, and why? Is any further action required?
- ❖ Identify further action to be taken.

3.2.9: Main Theme

- ❖ Health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way;
- ❖ It involves epidemiological, qualitative, and comparative methods to describe health problems of a population; identify inequalities in health and access to services, and determine priorities for the most effective use of resources;
- ❖ Health needs are those that can benefit from health care or from wider social and environmental changes;
- ❖ Successful health needs assessments require a practical understanding of what is involved, the time and resources necessary to undertake assessments, and sufficient integration of the results into planning and commissioning of local services.

Learner's Activity	Practical application of health needs assessment



Summary
Health needs assessment may find out the possible health related problems which could take possible steps for further solution. So it's a good method of finding problems and making related solution.

DRAFT

Study Skills

Short Questions

- What is Health Needs Assessment (HNA)
- Why do the undertake HNA?
- What are the benefits of HNA?
- What are the challenges of HNA?
- Which Resources are required to start an HNA?
- What are the the Five Steps of Health Needs Assessment?

References

Smith R. Rationing: the search for sunlight. BMJ. 1991; 303:1561–1562.

Ford HL, Gerry E, Airey CM, Johnson MH, Williams DRR. The prevalence of multiple sclerosis in the Leeds District. *J Neurol Neurosurg Psychiatry* 1998 (in press).

Department of Health and Social Security. Sharing resources for health in England: report of the Resource Allocation Working Party. London: HMSO; 1976.

Department of Health. The Health of the Nation: a strategy for health in England. London: HMSO; 1992.

Shanks J, Kheraj S, Fish S. Better ways of assessing health needs in primary care. BMJ. 1995; 310:480–481.

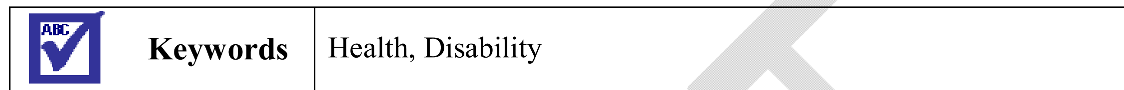
DRAFT

Lesson 3 Disability and Health Impact

Learning Objectives

After completion of this lesson learners will be able to

- Conceptualize the disability and health.
- Survival of disabilities and their barriers in health care with overcome.



Keywords	Health, Disability

Subject-matter

3.3.1 Basics about Disability and health

The International Classification of Functioning, Disability and Health (ICF) defines disability as an umbrella term for impairments, activity limitations and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports).

Over a billion people are estimated to live with some form of disability. This corresponds to about 15% of the world's population. Between 110 million (2.2%) and 190 million (3.8%) people 15 years and older have significant difficulties in functioning. Furthermore, the rates of disability are increasing in part due to ageing populations and an increase in chronic health conditions.

Disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive health care needs, others do not. However all people with disabilities have the same general health care needs as everyone else, and therefore need access to mainstream health care services. Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination.

3.3.2 Unmet needs for health care

People with disabilities report seeking more health care than people without disabilities and have greater unmet needs. For example, a recent survey of people with serious mental disorders, showed

DRAFT

that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study.

Health promotion and prevention activities seldom target people with disabilities. For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sex education programmes.

3.3.3 How are the lives of people with disabilities affected?

People with disabilities are particularly vulnerable to deficiencies in health care services. Depending on the group and setting, persons with disabilities may experience greater vulnerability to secondary conditions, co-morbid conditions, age-related conditions, engaging in health risk behaviors and higher rates of premature death.

Secondary conditions: Secondary conditions occur in addition to (and are related to) a primary health condition, and are both predictable and therefore preventable. Examples include pressure ulcers, urinary tract infections, osteoporosis and pain.

Co-morbid conditions: Co-morbid conditions occur in addition to (and are unrelated to) a primary health condition associated with disability. For example the prevalence of diabetes in people with schizophrenia is around 15% compared to a rate of 2-3% for the general population.

Age-related conditions: The ageing process for some groups of people with disabilities begins earlier than usual. For example some people with developmental disabilities show signs of premature ageing in their 40s and 50s.

Engaging in health risk behaviours: Some studies have indicated that people with disabilities have higher rates of risky behaviours such as smoking, poor diet and physical inactivity.

Higher rates of premature death: Mortality rates for people with disabilities vary depending on the health condition. However an investigation in the United Kingdom found that people with mental health disorders and intellectual impairments had a lower life expectancy.

DRAFT

3.3.4 Barriers to health care

People with disabilities encounter a range of barriers when they attempt to access health care including the following

Prohibitive costs: Affordability of health services and transportation are two main reasons why people with disabilities do not receive needed health care in low-income countries - 32-33% of non-disabled people are unable to afford health care compared to 51-53% of people with disabilities.

Limited availability of services: The lack of appropriate services for people with disabilities is a significant barrier to health care. For example, research in Uttar Pradesh and Tamil Nadu states of India found that after the cost, the lack of services in the area was the second most significant barrier to using health facilities.

Physical barriers: Uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities. For example, women with mobility difficulties are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand.

Inadequate skills and knowledge of health workers: People with disabilities were more than twice as likely to report finding health care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care.

3.3.5 Addressing barriers to health care

Governments can improve health outcomes for people with disabilities by improving access to quality, affordable health care services, which make the best use of available resources. As several factors interact to inhibit access to health care, reforms in all the interacting components of the health care system are required.

Policy and legislation: Assess existing policies and services, identify priorities to reduce health inequalities and plan improvements for access and inclusion. Make changes to comply with the CRPD. Establish health care standards related to care of persons with disabilities with enforcement mechanisms.

Financing: Where private health insurance dominates health care financing, ensure that people with disabilities are covered and consider measures to make the premiums affordable. Ensure that people with disabilities benefit equally from public health care programmes. Use financial incentives to encourage health-care providers to make services accessible and provide comprehensive assessments, treatment, and follow-ups. Consider options for reducing or removing out-of-pocket payments for people with disabilities who do not have other means of financing health care services.

DRAFT

Service delivery: Provide a broad range of modifications and adjustments (reasonable accommodation) to facilitate access to health care services. For example changing the physical layout of clinics to provide access for people with mobility difficulties or communicating health information in accessible formats such as Braille. Empower people with disabilities to maximize their health by providing information, training, and peer support. Promote community-based rehabilitation (CBR) to facilitate access for disabled people to existing services. Identify groups that require alternative service delivery models, for example, targeted services or care coordination to improve access to health care.

Human resources: Integrate disability education into undergraduate and continuing education for all health-care professionals. Train community workers so that they can play a role in preventive health care services. Provide evidence-based guidelines for assessment and treatment.

Data and research: Include people with disabilities in health care surveillance. Conduct more research on the needs, barriers, and health outcomes for people with disabilities.

3.3.6 WHO response in Disability

In order to improve access to health services for people with disabilities, WHO:

- guides and supports Member States to increase awareness of disability issues, and promotes the inclusion of disability as a component in national health policies and programmes;
- facilitates data collection and dissemination of disability-related data and information;
- develops normative tools, including guidelines to strengthen health care;
- builds capacity among health policy-makers and service providers;
- promotes scaling up of CBR;
- Promotes strategies to ensure that people with disabilities are knowledgeable about their own health conditions, and that health-care personnel support and protect the rights and dignity of persons with disabilities.

3.3.7 Health and Disability

People appear to regard health as one of the most important goods, more important than wealth, status, or professional success. Health is seen as special in part for instrumental reasons, because it is thought to be a prerequisite for many or most other goods. So the relationship of health to disability is

DRAFT

an issue of central concern for those who seek to replace or supplement a medical model of disability (Bickenbach 1993; Shakespeare 2006).

Two approach of health and disability are as follow:

The First Approach Distinguishing Disability from Disease:

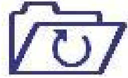
The distinction between disease and disability has received surprisingly little attention in the philosophical literature. Most statutory and other official definitions either treat serious diseases as disabilities or make “impairment”, “loss of function”, or “structural/functional abnormality” an element of disability, leaving the relationship of disease to disability unclear (e.g., Americans with Disabilities Act, 1990 or Disability Discrimination Act, 1995). One of the few detailed analyses of the relationship between disease and disability was offered by Ron Amundson, who proposed that disability should be understood as one of the three general consequences of disease, along with pain and death (Amundson 1992: 105–119). Amundson adopted Boorse’s value-neutral account of health, but argued that Boorse defined “disease” too broadly, as a “deviation from the functional organization of typical members of a species”—a definition which would encompass most disabilities. Amundson contended that it was both clearer and closer to common usage to treat disease as an atypical process that tended to result in disability, pain, or death.

The Second Approach: Health as More or Other than the Absence of Disease:

An alternative approach to the relationship between health and disability involves a broad or positive conception of health as more than, or distinct from, the absence of disease *or* disability. This approach has more and less instrumental versions. The former is represented by Nordenfelt’s account of health as the ability of an individual to reach her “vital goals”—those whose achievement is independently necessary and jointly sufficient for minimal happiness (Nordenfeldt 1995). On such an instrumental account, the relationship of disability to health depends on the goals that are considered vital or central and on the role of typical functions in achieving them. Some impairments will hinder the pursuit of some goals (goal-based accounts of health vary in whether or how they specify the relevant environment(s) affecting their pursuit), other impairments will have no effect, and some will *enhance* the pursuit of some goals. Any generalizations about the impact of impairments on health will depend on the assessment of their net effect on the pursuit of the specified goals.

DRAFT

Learner's Activity | Make a practical scenario of health and disability impact



Summary

Disability and health issue are vice versa. Poor health can make disability and another way disability makes poor health as less empowerment.

Study Skills

Short Questions

- How the lives of people with disabilities are affected?
- Describe WHO responses in Disability.
- Describe the relationship between heal and disability.

References

World Health Organization [WHO], 1948, "WHO Definition of Health", in Preamble to the Constitution of the World Health Organization, as adopted by the International Health Conference, New York, and 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 states.

Picciuto, E., 2015, March 16, "Mom with Disabilities and Daughter Reunited After Two-Year Court Battle", *The Daily Beast*.

Ratzka, A.D., 2004, "Model National Personal Assistance Policy", A project of the European Center for Excellence in Personal Assistance (ECEPA).

Roberts, M.A. and D.T. Wasserman (eds), 2009, *Harming Future Persons: Ethics, Genetics and the Nonidentity Problem*, Netherlands: Springer.

Brock, Dan, 2005, "Preventing Genetically Transmitted Disabilities while Pespecting Persons with Disabilities", in Wasserman, Wachbroit, and Bickenbach 2005b: 67–100.

Campbell, S.M., 2014, "When the Shape of a Life Matters", *Ethical Theory and Moral Practice*, 18(3): 565–575.

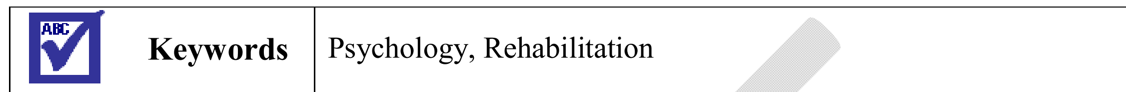
DRAFT

Lesson 4 Psychological Aspects of Rehabilitation Service Delivery

Learning Objectives

After completion of this lesson students will be able to…………

- Understand psychological aspect of disability and proper Rehabilitation.



Keywords	Psychology, Rehabilitation

Subject-matter

3.4.1 Basics of Psychological aspect of Rehabilitation

Psychiatric rehabilitation, also known as **psychosocial rehabilitation**, and sometimes simplified to **psych rehab** by providers, is the process of restoration of community functioning and well-being of an individual diagnosed in mental health or mental or emotional disorder and who may be considered to have a psychiatric disability.

From the 1960s and 1970s, the process of de-institutionalization meant that many more individuals with mental health problems were able to live in their communities rather than being confined to mental institutions. Medication and psychotherapy were the two major treatment approaches, with little attention given to supporting and facilitating daily functioning and social interaction. Therapeutic interventions often had little impact on daily living, socialization and work opportunities. There were often barriers to social inclusion in the form of stigma and prejudice.

Psychiatric rehabilitation work emerged with the aim of helping the community integration and independence of individuals with mental health problems. "Psychiatric rehabilitation" and "psychosocial rehabilitation" became used interchangeably, as terms for the same practice. These approaches may merge with or conflict with approaches based in the psychiatric survivor's movement, including the concept of user-controlled personal assistance services

3.4.2 Definition of Psychological Rehabilitation

Psychiatric rehabilitation is not a practice but a field of academic study or discipline, similar to social work or political science; other definitions may place it as a specialty of community rehabilitation or physical medicine and rehabilitation. It is aligned with the community support development of the National Institute on Mental Health begun in the 1970s, and is marked by a rigorous tradition of

DRAFT

research, training and technical assistance, and information dissemination regarding a critical population group (e.g., psychiatric disability) in the US and worldwide. The field is responsible for developing and testing new models of community service for this population group.

Intellectual disability

Intellectual disability, also known as *general learning disability*, and previously known as *mental retardation* (a term now widely considered to be offensive), is a generalized disorder characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors that appears before adulthood. It has historically been defined as an Intelligence Quotient (IQ) score under 70, but the definition now includes both one component relating to mental functioning and one relating to individuals' functional skills in their environment, so IQ is not the only factor.

Intellectual disability must have appeared in the developmental period, not only as an adult. By contrast, people with cognitive impairment have, or previously had, normal IQ, but now show confusion, forgetfulness and difficulty concentrating; cognitive impairment is typical of brain injuries, side effects from medications, and dementia.

Specific learning disability

A specific learning disability is a classification including several disorders in which a person has difficulty learning in a typical manner, usually caused by an unknown factor or factors, but sometimes caused by stroke or other medical problems. Specific learning disabilities include dyslexia and developmental coordination disorder and other disorders of psychological development. Unlike other intellectual disabilities, it is not indicative of general intelligence level, and many experts consequently do not consider it to be a true intellectual disability. Rather, people with a specific learning disability have trouble performing specific types of cognitive skills or if taught in conventional ways. A specific learning disability cannot be cured or fixed, but the effects can be mitigated by the use of different learning strategies.

Cognitive Disability

In order for students to be diagnosed with a **cognitive disability**, they must have impairments in *intellectual functioning* and *adaptive behavior*. Additionally, the symptoms must be present before a child becomes 18 years old.

Intellectual functioning refers to a person's ability to plan, comprehend, and reason. A child's intellectual functioning can be assessed by an intelligence test. The most common intelligence test

that you've probably heard of is the **IQ test**. Generally, a child with scores of *70-75 or lower* is classified as having a cognitive disability.

3.4.3 Types of Cognitive Disabilities

The most common type of cognitive disability is a **mild cognitive disability**, accounting for around 85% of all cognitive disabilities. Kids in this category have IQ scores between 55 and 70 and are usually included in the regular classroom. Common characteristics of mild intellectual disabilities include difficulty remembering previously learned material, problems making predictions, short attention spans, poor short-term memories, and challenges generalizing skills to new situations.

The second-most common cognitive disability is a **moderate cognitive disability**. Students with this type of disability have IQ scores between 30 and 55. These kids may have simple communication skills, difficulties in social situations, and also might present with noticeable delays. About 10% of kids who've been diagnosed with a cognitive disability fall in the moderate range.

The third type of cognitive disability is a **severe cognitive disability**. Kids with severe cognitive disabilities have IQ scores that fall under 30 and will have few communication skills, and will need direct supervision. Of all cognitive disabilities, only about 3-4% of children have a severe cognitive disability.

Cognitive Disability and Well-Being

The differences among standard accounts of well-being are particularly significant in thinking about the well-being of people with severe cognitive impairments. We believe that a separate discussion of this topic is warranted, but not because cognitive impairments are in a class by themselves. As we have noted, there are great differences among all types of impairments. Cognitive impairments, however, have until recently received relatively little attention in philosophy, and we give them special emphasis as a corrective.

Subjective accounts of well-being, hedonic and simple-desire accounts, appear easier to apply to people with such impairments, for two reasons. First, joy, pain, satisfaction, and frustration are more readily conveyed and assessed than the more complex mental states that informed-desire and objective list theories take into account. Second, people with cognitive impairments appear less capable of enjoying or attaining some items on standard objective lists: not merely various forms of achievement, but also a variety of social relationships and aesthetic experiences. More broadly, persons with cognitive impairments may be unable to form and pursue a conception of the good life. The conviction that persons with severe cognitive impairments can and often do enjoy relatively high levels of well-being thus seems to favour a more subjective account of well-being than that adopted for everyone else.

DRAFT

3.4.4 Principles of Psychological Rehabilitation

The mission of psychiatric rehabilitation is to enable with best practices of illness management, psychosocial functioning, and personal satisfaction. Treatments and practices towards this is guided by principles.

There are seven strategic principles:

1. Enabling a normal life.
2. Advocating structural changes for improved accessibility to pharmacological services and availability of psycho-social services.
3. Person-cantered treatment.
4. Actively involving support systems.
5. Coordination of efficient services.
6. Strength-based approach.
7. Rehabilitation isn't time specific but goal specific in succeeding.

Principles guides to better psychosocial rehabilitation practices. Recovery through rehabilitation is defined possible without complete remission of their illness, it is geared towards aiding the individual in attaining optimum mental health and well being

3.4.5 Services of Psychological Rehabilitation

Psychiatric rehabilitation services may include community residential services, workplace accommodations, supported employment or education, social firms, assertive community treatment (or outreach) teams assisting with social service agencies, medication management (e.g., self-medication training and support), housing, programs, employment, family issues, coping skills and activities of daily living and socialising. Traditionally, "24-hour" service programs (supervised and regulated options) were based upon the concept of instrumental and daily living skills as formulated in the World Health Organization (WHO) definition.

Core principles of effective psychiatric rehabilitation (how services are delivered) must include:

- providing hope when the client lacks it;
- respect for the client wherever they are in the recovery process;
- empowering the client;
- teaching the client wellness planning; and

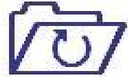
- Emphasizing the importance for the client to develop social support networks.

Psychiatric rehabilitation (what services are delivered) varies by provider and may consist of eight main areas:

- Psychiatric (symptom management; relaxation, meditation and massage; support groups and in-home assistance)
- Health and Medical (maintaining consistency of care; family physician and mental health counselling)
- Housing (safe environments; supported housing; community residential services; group homes; apartment living)
- Basic Living Skills (personal hygiene or personal care, preparing and sharing meals, home and travel safety and skills, goal and life planning, chores and group decision-making, shopping and appointments)
- Social (relationships, recreational and hobby, family and friends, housemates and boundaries, communications & community integration)
- Vocational and/or Educational (vocational planning, transportation assistance to employment, preparation programs (e.g., calculators), GED classes, televised education, coping skills, motivation)
- Financial (personal budget), planning for own apartment (start-up funds, security deposit), household grocery; social security disability; banking accounts (savings or travel)
- Community and Legal (resources; health insurance, community recreation, memberships, legal aid society, homeownership agencies, community colleges, houses of worship, ethnic activities and clubs; employment presentations; hobby clubs; special interest stores; summer city schedules)

DRAFT

Learner's Activity	Make a practical scenario of psychological rehabilitation

 **Summary**
Rehabilitation should be ensured all aspects such as physical, mental, psychological, social and also economical of disability for getting better outcomes of rehabilitation and reintegration.

Study Skills

Short Questions

- Definition of Psychological Rehabilitation
- What are the Types of Cognitive Disabilities?
- What are the Principles of Psychological Rehabilitation?
- What Services available for Psychological Rehabilitation?

DRAFT

References

Rudnick, Abraham; Roe, David, eds. (2011). Serious Mental Illness: Person-cantered Approaches. London: Radcliffe.

Raskin, Nathaniel J. (2004). Client-Cantered Therapy and the Person-Cantered Approach. Ross-on-Wye, UK: PCCS Books.

Dion, George L.; Anthony, William A. (March 1987). "Research in psychiatric rehabilitation: A review of experimental and quasi-experimental studies". Rehabilitation Counselling Bulletin. **30** (3): 177–203.

Howie the Harp (May 1993). "Taking a new approach to independent living". Hospital & Community Psychiatry. 44 (5): 413.

Anthony, William A. (2009). "Editorial: Psychiatric rehabilitation leadership." Psychiatric Rehabilitation Journal. 33 (1): 7–8.

DRAFT