

ARE THERAPISTS AWARE OF THE NEEDS OF PEOPLE WITH DISABILITIES?

ABSTRACT: *This article challenges therapists to find out what the needs of people with disability are before planning community based rehabilitation services. It also establishes that therapists and people with disabilities have different ideas about the needs of people with disability.*

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The emphasis of Health Care Services in South Africa is shifting towards primary health care, of which Community Based Rehabilitation (CBR) is an integral part (Office of the Deputy President, 1997). In 1994 CBR was defined as "a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities" (ILO/UNESCO/WHO, 1994). This is "implemented through the combined effort of disabled people themselves, their families and communities, and the appropriate health, vocational and social services." The white paper for the transformation of the health system in South Africa also clearly states that all health workers and professionals should commit themselves to improving the health status of all people in their catchment areas and not only have a responsibility towards the people attending their clinics/ hospitals (Department of Health, 1997).

Therapists are therefore expected to offer services within the framework of CBR (Teager, 1998). This is new to many South African therapists, who may consequently feel that they lack the necessary skills. In August 1997 a workshop on Community Based Rehabilitation (CBR) was held as part of the University of the Witwatersrand Faculty of Health Sciences Seventy-fifth Jubilee Congress. This workshop aimed to help therapists plan CBR services by: equipping therapists with some strategic planning skills, teach-

ing them participatory rural appraisal techniques (Kumar, 1998), bringing them together with people with disabilities, and challenging the stereotypes of professional knowledge. The first part of the workshop, i.e. establishing the needs of people with disability, is presented here. It is hoped that by presenting the outcome of the workshop therapists will gain a clearer idea of attitude shifts needed in order to develop comprehensive primary health care in terms of rehabilitation.

METHOD

In order to plan a CBR programme, therapists need to discover what the needs of people with disability in the community are (Helander, 1992). Therapists (physiotherapists, speech therapists and occupational therapists) participating in the workshop were put into one group (n=20). A group of volunteers from People for Awareness of Disability Issues (PADI) and from the Disabled Students' Programme at the University of the Witwatersrand (all with disabilities) were put into another group (n=10). Each group then had to discuss what they felt were the needs of people with disability, using a Venn diagram (Kumar, 1998), which is a participatory rural appraisal tool. The Venn diagram was done as follows:

The groups firstly had to decide what the needs of people with disability in the community are. Each group was given the same number of circles of different sizes: large, medium, small and very small. The groups then decided which of the needs they had identified went onto which circle: A big need would go on the large circle, a very small need would go on the very small circle etc. Once each circle had a need written onto it, the group then had to organise the circles into a pattern so that the needs that were related in some way were put together. Needs that did not have any relationship

to each other could be put separately. The pattern of circles was then displayed on the wall and described verbally. This arrangement of circles is called a Venn diagram (Kumar, 1998).

There were a few blind people in the group with disabilities. One of the blind students therefore typed the needs identified by this group in Braille. The Braille strips were then attached to the correct circles. The needs were also written in pen onto the circles. Once the two groups had completed this exercise they presented their diagrams to each other. The people with disabilities showed their Venn diagram in Braille first, before showing the written terms. The headings of the therapist group were then also typed in Braille and put onto their Venn diagram.

Once the Venn diagrams were completed, the people with disabilities unfortunately had to leave, as they had to attend lectures. The rest of the workshop was spent using other Participatory Rural Appraisal tools to draw up a strategic plan to meet the needs of people with disabilities.

RESULTS

Figures 1 and 2 show the Venn diagrams completed by the people with disabilities and the therapists respectively.

The two groups saw the needs of people with disability in the community very differently.

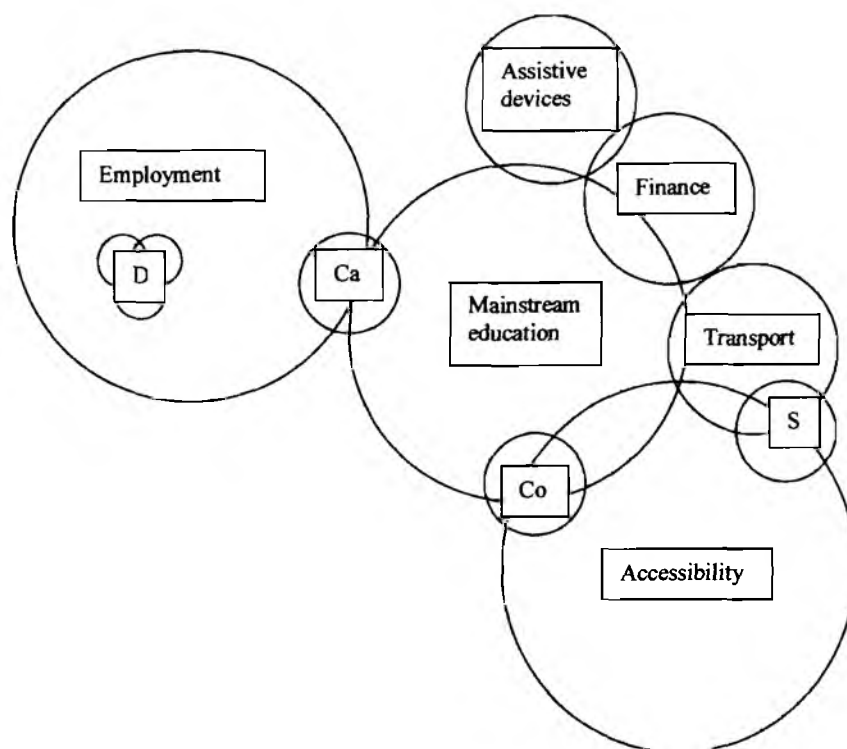
The only similarities were that both groups assigned the same importance to the needs for finance and social interaction. Finance was put on a medium sized circle by both groups, while both groups put social and spiritual needs and social interaction on a small sized circle.

All the other elements in the Venn diagrams were different. The people with disabilities dealt with "real life practicalities" or activities of daily living (such as mainstream education, accessibility, trans-

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FIGURE 1: PEOPLE WITH DISABILITY'S VENN DIAGRAM



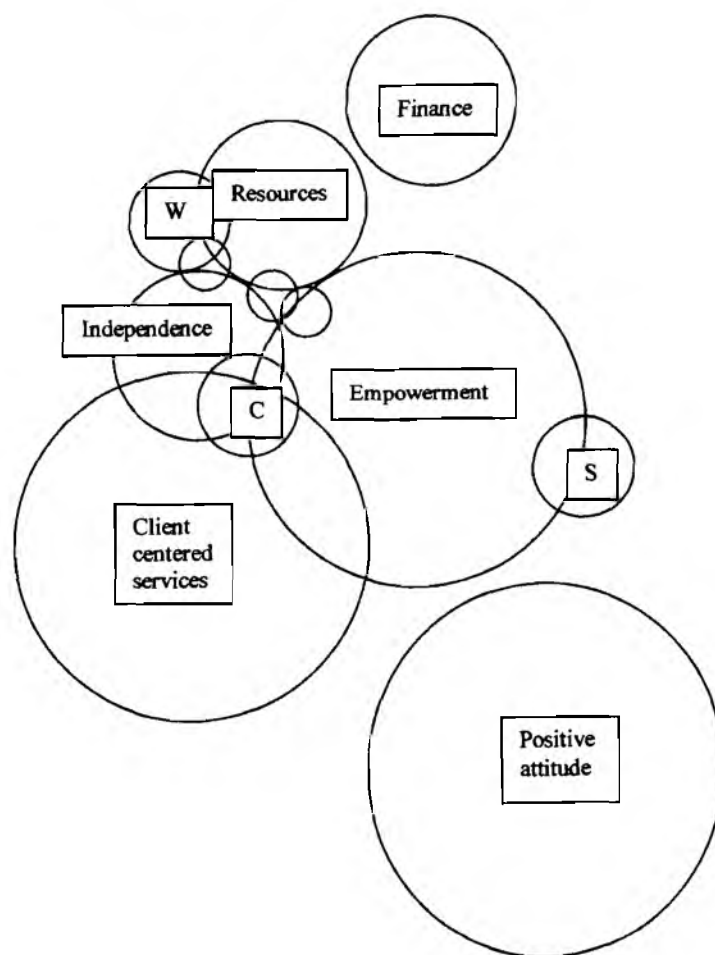
port) (figure 1), while the therapists tended to deal with “concepts” (such as empowerment and independence) (figure 2). In addition, the three biggest needs identified by therapists and people with disability differed completely: Therapists stated these as being “empowerment”, “a client centred approach” and “positive attitude” (figure 2), while people with disability stated these as being “employment”, “main stream education” and “accessibility” (figure 1).

Therapists assigned the need for assistive devices to the very small circle (figure 2), while people with disability assigned it to a medium circle (figure 1).

The needs for resources, independence, empowerment, a client centred approach and positive attitude were only mentioned by the therapists (figure 2). These were the main needs identified by therapists. On the other hand, the needs that were only mentioned by people with disability included counselling, career choice, accessibility (note this was a main need of the people with disabilities) and disability grants (which was seen as separate from finance) (figure 1).

In the next part of the workshop, after the people with disabilities had left to attend their lectures, the therapists used the list of needs they had drawn up (not the list drawn up by the people with disabilities) in order to work out a strategic plan to meet the needs of people with disabilities.

FIGURE 2: THERAPISTS' VENN DIAGRAM



DISCUSSION

This exercise demonstrated that therapists do not really know what the needs of people with disability are. Therapists dealt with "concepts", while people with disabilities dealt with "practicalities". Could it be that we mean the same thing but speak different languages, or could it be that we work from opposite ends of the spectrum? Perhaps positive attitudes and a client centred approach are therapists' needs for successful interaction with clients rather than the needs of the client. A positive attitude that leads to empowerment of people with disability and a client-centred approach by therapists could, however, result in mainstream education, employment and accessibility. We should guard against semantics hindering the trust between a client and a therapist, as well as goal setting and progress. To avoid conflict, goals should be decided on jointly between people with disabilities and therapists and those goals should be measurable (Office of the Deputy President, 1997). Rehabilitation also needs to be made understandable to all (Philpot and Pillay *et al*, 1995; Helander, 1992). This implies using simple words, explaining what therapists can and cannot offer and ensuring that clients know all the options available to them, including those outside the therapist's professional realm. Therapists need to ask themselves if clients understand what they mean, what they can do and the process of doing it. Therapists also need to understand what the client means or needs in rehabilitation, while clarifying the processes and time plans for clients to reduce frustration.

The people with disabilities' focus on needs such as education and career during this workshop were understandable, as they were students at the beginning of their adult lives. Other groups of people with disability may have listed other needs, while the same could also be said for the group of therapists. It is interesting to note that people with disability expressed disability grants and finance as different needs. This could mean that people with disability that are able to work need the ability to earn money, while some people with disabilities are unable to work and are dependant on grants.

It is remarkable that the therapists did not perceive accessibility as a need of people with disabilities. This is considered as an important need for people with disabilities (Office of the Deputy President, 1997). Lack of identification with people with disability or lack of experience with

disability outside of the "institution" or hospital may have accounted for this discrepancy. "Empowerment" and "client-centred" can be seen as the changes the therapist has to make. These are "woolly" terms showing that the therapists do not have the "nuts and bolts" of what people with disabilities need.

The much smaller importance assigned to the need for assistive devices by therapists compared to people with disabilities was also notable. Assistive devices play an important role in the lives of people with disabilities (Office of the Deputy President, 1997), yet therapists often do not educate people with disabilities about the options they have with assistive devices, nor do they give them much choice in the selection.

For community based rehabilitation to be successful, the needs of people with disability need to be considered. This is an important aspect of the key principles of CBR, as described by Helander (1992), the 1994 Joint Position Paper on CBR (ILO, UNESCO *et al*, 1994) and the Wits-Tintswalo Community Rehabilitation Worker Training Programme (Philpot and Pillay *et al*, 1995).

As the second part of the workshop was based on using the needs identified on the Venn diagrams to develop a strategic plan for CBR, it came as a surprise to the facilitators of the workshop that the therapists continued using the needs list they had drawn up, ignoring the list of the people with disabilities. Although they had seen that their needs list did not correspond with the list of the people with disabilities, they silently and unconsciously worked out a strategic plan for their list only.

Therapists need to start working with people with disabilities as equal partners (Helander, 1992). The national organisations for people with disabilities have an important role to play to facilitate this process (Office of the Deputy President, 1997). Accepting attitudes to people with disabilities (Philpot and Pillay *et al*, 1995; Office of the Deputy President, 1997) are easily spoken about, but often not practised, as we saw during this workshop. Attitudes are difficult to change (Payne, 1998; Office of the Deputy President, 1997), but this is clearly necessary (Helander, 1992). Ideally the facilitators should have ensured that the people with disabilities were able to attend the whole workshop. It is obvious that therapists and people with disabilities need to develop strategic plans for CBR together (Office of the Deputy President, 1997)

and that it is not good enough for therapists to gather information about needs and then not use it.

CONCLUSION

The workshop illustrated that therapists were not aware of the needs of people with disabilities. In order for it to be effective, community based rehabilitation has to aim at the needs of people with disabilities and not at what therapists think these needs are. Therapists need to be exposed further to the needs of people with disabilities and work out joint solutions on how these needs can be met. Participatory rural appraisal techniques can be used for this joint venture.

EDITOR'S NOTES

The "people with disability" group may well be a biased group as they were mainly university students. However, this does not negate the message of this article - therapists are not always in touch with the needs of their clients. Furthermore we cannot generalise - different groups of people with disability will surely have different needs.

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