ROLES OF SOCIAL WORKERS IN INDONESIA:
Issues and Challenges in Rehabilitation For People With Disability

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ROLES OF SOCIAL WORKERS IN INDONESIA: ISSUES AND CHALLENGES IN REHABILITATION FOR PEOPLE WITH DISABILITY [1]

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Our culture places a high values on having a beautiful body. We work out at health clubs, and we spend large proportions of our incomes on clothes, cosmetics, hair stylists, and special diets to look more attractive. Beauty is erroneously identified with goodness and ugliness with evil. Movies, television, and books portray heroes and heroines as physically attractive and villains as ugly. Snow White, for example, was lovely, whereas the evil witch was horrible looking. Children are erroneously taught that being physically attractive will lead to the good life, whereas having unattractive features is a sign of being inferior.

Charles H. Zastrow (2000: 562)

The emphasis on the body beautiful in our community has posed psychological and social barriers confronting people with disability (PWD). [3] As such, it calls for distinctive responses from such a human and helping profession as social work. Whilst social workers need to address psychological issues and behavioural adjustments of PWD, their interventions should also focus on social construction of disability and environmental factors influencing rehabilitation for PWD. After reviewing the figure and definitions relating to disability, this paper explores psychosocial issues confronting PWD and the challenges for social workers working in rehabilitation for PWD. Finally, the process of social work services and the roles of social workers with reference to the rehabilitation settings are examined.

THE FIGURE AND DEFINITIONS ON DISABILITY

It is estimated that more than 600 million people in the world live with some form of disability, and more than 400 million of them live in developing countries (Sen and Wolfensohn, 2004). In developing world, Sen and Wolfensohn argue that between ten

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[3] In this paper, the term PWD is frequently used to refer to person or people with disability or disabilities, mainly physical disabilities. However, in the interest of conserving print space, original term of the text or serving announcing time, the terms "disabled people" or "Difable" (an acronym from Different Able People or People with Different Ability) are sometimes employed.

and twenty percent of the population can be categorised as PWD in one way or another. In developing nations, however, reliable data on disability does not generally exist. This partly explain why the nature of disability and its extent vary across counties and why rates of disability in many developing economies are unbelievably very low (Mont, 2005).

As definitional and measurement problems are improved, estimates on the incidence of disability notably jump (Mont, 2005). Recently, a new approach to measure disability based on the WHO's new International Classification of Functioning, Disability, and Health (ICF) is employed by a few countries and has resulted more reliable figure on disability. In 1991, for example, the census in Brazil reported that the disability rate is only 1 to 2 percent, but in the 2001 census, employing the improved method, the rate of disability is reported to reach 14.5 percent (Mont, 2005: 1).

Definition of PWD in Indonesia can be found, amongst others, in the Act Number 4 of 1997 concerning Disable People. It is stipulated that: "Disabled person is someone who has physical and/or mental abnormality, which could disturb or be seen as obstacle and constraint in performing normal activities, and consisted of (a) physically disabled, (b) mentally disabled, (c) physically and mentally disabled."

Although the Act provides definition and classifications of disability, there is no obvious national standard used to measure PWD in surveys and censuses. As a result, there are a number of versions of statistical data concerning the number of PWD in Indonesia. According to the Centre for Data and Information of the Ministry of Social Affairs (Pusdatin, 2006) there are about 2,429,708 PWD in Indonesia or about 1.2 percent of the total population. However, this figure raises questions. Not only because this figure is extremely lower than that is estimated by Sen and Wolfensohn and Mont, but also because the data itself is quite different from other sources of the national bodies.

Apart from differences in time references, for example, Ariani Soekanwo (2004: 2), the Chairwomen of Indonesian Association of Women with Disabilities, raised dissatisfaction concerning the unreliable figure of disability in Indonesia. She showed that according to the Ministry of Social Affair, there are about 3.11 percent PWD all over Indonesia. Whilst, the Legislative Body stated the amount of PWD in Indonesia is 5 percent of the total population in 1997. In addition, the data registration for national election joint work between Statistical Office and Electoral Authority in 2003, showed that the number of PWD in Indonesia is about 0.5 percent of the total population.

THE ISSUES

As elsewhere, PWD in Indonesia confront multifaceted issues derived from both internal and external factors. As indicated above, the emphasis on the "perfect" and

attractive physique has caused PWD to be the objects of unkind jokes and has usually led them to be either ignored or treated as inferior (Zastrow, 2000). Zastrow asserts that if PWD are designated as if they are inferior or second-class citizens, they are likely to have negative self-concept viewing themselves as inferior.

Another consequence of this misplaced values, according to Wright, has led society to believe that PWD "ought" to feel inferior (Zastrow, 2000). Wright has coined the term "requirement of mourning" which means that psychologically, people who spend a great deal of time, money, and effort to be physically attractive want PWD to mount the disability, because the "perfect" people need feedback that it is worthwhile and important to strive to have a body beautiful physique (Zastrow, 2000: 562).

Social relationships

As a result of being ignored, rejected, or more subtly evaded by those who have no disabilities, PWD may experience barriers in social relationships with their peers as well as with wider community members. Patronizing sympathy, diverted stares, artificial levity, and awkward silences create strained social interactions and interpersonal relations between PWD and non-PWD tend to create a superior-inferior model of social interaction (DuBois and Miley, 2005).

Zastrow (2000) shows studies revealing that many people cut short their interactions with PWD; they are usually do not want to make any direct remarks about disability; and that the PWD are sensitive to such insincere interactions. The "normal" people are usually uncomfortable when a PWD is near because they are uncertain about what is appropriate and inappropriate to say and behave and they are fear of offending the PWD (Zastrow (2000: 562). People generally show their discomfort in a variety of ways, such as through fixed stares away from PWD, abrupt and superficial conversations, compulsive talking, or an artificial seriousness (Zastrow (2000: 562).

Words with dignity

The fact that social construction often stigmatizes PWD can be seen partly from definitions on disability that often use words containing some negative connotations (See Table 1). DuBois and Miley (2005: 334) stated that fundamentally our words represent our attitudes and impinge on our understanding of people and their situation, and that "person first language" communicate respect.

> Worlds are powerful. Words shape our thinking, inform our interpretations, and predispose our conclusions. It stands to reason that if social work is to be an empowering profession, then the words, labels, and metaphors that social workers draw on to describe their work must promote strengths and facilitate empowerment (DuBois and Miley, 2005: 199).

In this case, Indonesian movement activists in 1998 created a new definition of PWD, that is "Difable": an acronym from Different Able People or People with Different Abilities (Cak Fu, 2006).

Table 1: Words with Dignity to Avoid Negative Connotations or Attitudes

The following words have strong negative connotations	The following words are more affirmative and reflect a more positive attitudes
Do not use: Handicap, the handicapped, crippled with, victim, spastic, patient (except in hospital), invalid, paralytic, stricken with, birth defect, inflicted, afflicted/afflicted by, incapacitated, deaf and dumb, deaf mute, confined to a wheelchair, restricted to a wheelchair, wheelchair bound, normal (acceptable only for quoting statistics)	**Words with dignity:** Physically disabled, person with a disability, person who has multiple sclerosis, person who has muscular dystrophy, paraplegic (person with limited or no use of lower limbs), quadriplegic (person with limited or no use of all four limbs), person who has cerebral palsy, person who had polio, person with mental retardation, person with mental disability, person who is blind, person who is visually impaired, person who has a speech impairment, person with a learning disability caused by "_____", disable since birth, born with "_____", deaf person, pre-lingually (deaf at birth) deaf post-lingually (deaf after birth), profoundly deaf (no hearing capability, hearing-impaired (some hearing capability), person in a wheelchair, person who walks with crutches, non disabled (referring to non-disabled persons as normal insinuates that disabled persons are abnormal)
Basic guidelines: make reference to the person first, the disability, i.e.: "A person with a disability" rather than a "disabled person." Use an adjective as a description, not a category or priority, i.e.: "the architect in a wheelchair" rather than "the wheelchair architect"	

Source: DuBois and Miley (2005: 335) modified

Although this term may sound "strange" to native English speakers, this term is made to represent the real life of PWD who have different physical and mental conditions. This term is expected to deconstruct the definition of disable people itself and to celebrate that every body is able and no body is disabled. This means that every human being owns an ability to perform everything even though in a different way from others (Cak Fu, 2006). For illustration, people who had polio can perform driving car and cooking food. Although the ways the people who had polio drive and cook are different from other people who had no polio, the output of these activities are not quite different.

Poverty

Elwan (1999) estimated that 15 percent to 20 percent of poor people in developing economies have a disability. In the Asian and Pacific region, it is estimated that of 160 million PWD, over 40 percent are living in poverty (UN ESCAP, 2002). Mont's study (2005: 1) quoted that in Nicaragua, PWD have much lower rates of education, much higher rates of illiteracy, and much lower rates of economic activity; in Serbia, 70 percent of PWD are poor and only 13 percent have access to employment; in Sri

Lanka, about 90 percent of PWD are unemployed; and in India, PWD are more likely to be poor, held fewer assets, and incur greater debts than general population. The two-way link between poverty and disability often traps the poor and locks them into a vicious circle (Mont, 2005).

> Poor people are more at risk of acquiring a disability because of lack of access to good nutrition, health care, sanitation, as well as safe living and working conditions. Once this occurs, people face barriers to the education, employment, and public services that can help them escape poverty. These barriers include intense stigma, as well as barriers related to infrastructure and program design (Mont, 2005: 2)

Moreover, Mont (2005: 2) showed that the disability of one member affects whole families. In Uganda, Mont asserted that disabled household heads impact a significant drop off in school attendance for children; whilst in Nicaragua, family members spent on average 10 hours a day caring for disabled people, which must affect their employment and other home production.

Management of services

In terms of service management in rehabilitation for PWD in Indonesia, a number of issues has been found and hinders the effectiveness of the rehabilitation processes and outputs (MOSA, 2003a: 15):

- Lack of reliable and up-to-date data on living conditions and characteristics of PWD according to their types of disabilities;
- Lack of qualified social workers who have specialized expertise to work with PWD according to their type of disabilities, such as working with person with physical disability, visual disability, hearing disability, intellectual disability, etc.
- Limited rehabilitation facilities and infrastructures required by PWD;
- Lack of public facilities that can be accessed by PWD;
- Limited job opportunities that fit with the abilities of PWD.

THE CHALLENGES

The above issues necessitate challenges for social workers to work out effective methods. Beaulaurier and Taylor (1999: 169) state that for many PWD "the physical and attitudinal barriers to employment, mobility and other life activities may be more persistently problematic than their impairments in and of themselves." Therefore, social workers must not focus solely on micro issues and ignore the impact of environmental influences in rehabilitation. Rehabilitation programmes need to involve empowering relationships so as to enhance competence and functioning of the PWD in dealing with their feelings and confronting the effects of social marginality and stigma. Whilst interventions need to involve attitudinal and

behavioural modifications, such aspects as economic, social, and legal need to be taken into account as well (DuBuis and Miley, 2005: 336).

Strengths perspectives

Collaborative, strengths-centred perspectives can be applied by social workers to recognise and rely on PWD first and their expertise in order to identify their situations, including their needs, priorities, and hopes for the future (DuBuis and Miley, 2005). In the case of vocational rehabilitation, for instance, the main goal of the rehabilitation may be designed to eliminate the disability, if that is possible, or to reduce or alleviate the disability to the greatest degree possible by enhancing client's employability and emphasizing the importance of employment for self-sufficiency and independence. Effective rehabilitation planning should encourage client's participation in all aspect of decision making and provide chances for PWD to achieve increased autonomy and independence.

Socially constructed solutions

Since disability is partly a social problem, successful programmes in vocational rehabilitation need to involve socially constructed solutions, especially to deal effectively with the realities of the social and occupational world. In developing PWD's capabilities social workers should consider the interactions between PWD and their physical and social environments as well as confront social devaluation, stigma, social marginality, and environmental pressures (DuBois and Miley, 2005: 338).

Rehabilitation policies and programmes in schools, training centres and workplace should be directed to overcoming prejudicial attitudes and discriminatory practices. According to Bricout and Bentley, research shows that "to effect sufficient, significant, and consistent changes of attitudes toward those who have disabilities and to create opportunities for employment requires substantial employer education in the successful accommodation of qualified workers with disabilities" (DuBois and Miley, 2005: 338).

SOCIAL WORK

The International Federation of Social Workers, in collaboration with the International Association of Schools of Social Work, has recently endorsed a new definition of social work (IFSW, 2000; Suharto, 2006).

> The social work profession promotes problem solving in human relationships, social change, empowerment and liberation of people, and the enhancement of society. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (IFSW, 2000: 1).

This definition places social work as a human and helping profession to respond to "the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop full potential, enrich their lives, and prevent dysfunction" (IFSW, 2000: 1). According to the IFSW (2000: 1), "the holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical and socio-economic conditions." In short, social work practice is about planned social change, and therefore, social workers are the change agents focusing their interventions on the social intersections between individual and society (Tan and Envall, 2004: 5).

In line with the mission as human and helping profession, social workers' interventions are generally initiated to strengthen human functioning as well as enhance the effectiveness of the structures in society that provide resources and opportunities for clients and beneficiaries of services, including PWD. These goals lead social workers to empower clients' capabilities, link them with resources and foster changes that make social agencies and institutions more responsive to clients' needs (DuBois and Miley, 2005). In short, social workers' interventions are geared to achieve the following goals (Zastrow, 1999; Zastrow, 2000; DuBois and Miley, 2005: 12):

- Enhancing people's capabilities to resolve problems, cope, and function effectively;
- Linking clients with needed resources;
- Improving the social service delivery networks; and
- Promoting social justice through the development of social policy.

SOCIAL WORK AND SOCIAL WORKERS IN INDONESIA

In Indonesia, the roots of social work may be found in the extensive volunteer movements during the formative years of Indonesia in 1940s. Social work sprang from the need to respond to an increasing number of people experiencing social problems, especially relating to mass poverty. These voluntary activities gradually became more formalized as numerous social organisations and welfare agencies were formed. For example, Yayasan Pembinaan Anak-Anak Cacat (YPAC) or The Indonesian Society for the Care of Disabled Children was one of the oldest voluntary organisations employing paid social work positions (See Box 1).

Significant development leading to the emergence of social work as an occupation was the establishment of training programmes of social work in Bandung, namely *Kursus Dinas Sosial* A (KDSA) or preliminary course for social personnel level A in 1957 which was then replaced by Kursus Kejuruan Sosial Tingkat Tinggi (KKST) or higher course for skilled social workers. These two vocational training programmes were designed to train employees of the Ministry of Social Affairs (MOSA) for one and two years respectively. In 1964, Sekolah Tinggi Kesejahteraan Sosial (STKS) or School of Social Welfare was established in Bandung to replace the former short

training programmes of KKST. STKS provides undergraduate and graduate programmes to educate civil servants of the MOSA and other government agencies to become professional social workers (at least by education) (Suharto, 2005).

Box 1: The Profile of YPAC

YPAC, the Indonesian Society for the Care of Disabled Children, was established in the early 1950s in response to the polio epidemic occurred in Indonesia. Expansion of services has allowed the society to provide assistance to groups of children with physical disabilities such as cerebral palsy. YPAC currently operates 16 branches throughout Indonesia with its core activities include giving rehabilitation services for children with physical disabilities which includes special school programs.

In 1978, YPAC developed the concept of CBR (Community-based Rehabilitation) with an early detection and early intervention programmes for disability in young children. The CBR Development and Training Center (CBRDTC) was established in 1989 and by 1991 the first international CBR workshop was held in the facilities. The main objective of the Center is to develop the concepts of CBR while not providing direct service for PWD. The programmes and other activities of the CBRDTC are directed toward solving disability issues through community development.

The CBR Center office and training complex is located in Solo in Central Java and has a 5,000 square meter facility consisting of fully accessible guest rooms, training rooms, auditorium and office space. The Center is also equipped with audio visual equipments including 20 simultaneous translation earphones and an accessible bus for 8 wheelchairs or 18 people.

Source: APDC (2006: 1)

There are three important professional associations that support the development of social work in Indonesia: (a) Indonesian Association of Schools of Social Work (Ikatan Pendidikan Pekerjaan Sosial Indonesia/IPPSI); (b) Indonesian National Council on Social Welfare (Dewan Nasional Indonesia untuk Kesejahteraan Sosial/DNIKS); and (c) Indonesian Association of Professional Social Workers (Ikatan Pekerja Sosial Profesional Indonesia/IPSPI). However, since there is no certification or accreditation for licensing social work practitioners, social work in Indonesia has not been categorised yet as "a full-fledged profession". Following Greenwood's "attributes of a profession" (Morales and Sheafor, 1989; DuBois and Miley, 2000), for example, social work in Indonesia has already had fundamental bodies of knowledge, skills, and values that direct practical activities, but a formal and widely acceptable professional association which has authority to regulate and control its own membership, professional practice, education, and performance standards, is still absent.

The above conditions partly explain why social workers in Indonesia have generally been referred to as encompassing three categories of social workers: voluntary, functional and professional social workers.

1. Voluntary social workers

They are people who have no educational background in social work but working in non-governmental organisations providing social services and doing social work-related activities.

2. Functional social workers

They are civil servants appointed to held functional positions as social work practitioners in different settings of social service agencies under the auspices of MOSA, Ministry of Health and provincial or district governments. Different from those who held structural positions and are responsible for conducting administrative and managerial tasks, functional social workers are responsible for planning, executing, and developing social service programmes. Most functional social workers have bachelor degree in social work, but for those who have non-social work degree are required to complete compulsory and continuous training programmes in social work. At the moment, there are about 800 functional social workers consisting of two big groups of "skilled" social workers and "expert" social workers (Pekerja Sosial Terampil and Pekerja Sosial Ahli).

3. Professional social workers

According to the membership requirements of the Indonesian Association of Professional Social Workers, professional social workers are those who have at least bachelor degree in social work or social welfare. Currently there are about 33 public and private universities offering undergraduate programmes in social work or social welfare and 4 public universities (University of Indonesia, Bandung School of Social Welfare, Bogor Institute of Agriculture, and State Islamic University of Sunan Kalijaga Yogyakarta) which run master programmes in social work. Until now, Bandung School of Social Welfare itself has graduated more than 10,000 alumni.

ROLES OF SOCIAL WORKERS

The social work roles and activities are differentiated depending on the settings and clients they are working for. Even in the setting of rehabilitation for PWD, social work roles would be different according to each institution, method of practice and client the social worker work with. In general, roles of social workers fall into three broad functions: consultancy, resource management, and education, which are associated with each social work strategy (See Table 2) (DuBois, 2000: 227).

Table 2: Social Workers Roles and Strategies

Function	Clients/Consumers/Beneficiaries		
	Individual and families	Formal groups and organisations	Community and society
Consultancy			
Role	Enabler	Facilitator	Planner
Strategy	Finding solution	Organisational development	Research and planning
Resource management			
Role	Broker/advocate	Convener/mediator	Activist
Strategy	Case management	Networking	Social action
Education			
Role	Teacher	Trainer	Outreach
Strategy	Information processing	Professional training	Community education

Source: DuBois and Miley (2005: 228) modified

Rehabilitation for PWD generally refers to the restoration of the fullest physical, mental, social, vocational, and economic usefulness of which they are capable (Zastrow, 2000). Programmes are usually designed to include vocational training, vocational counseling, medical rehabilitation, selective job placement, psychological adjustment. Whilst clients differ in which of these services are needed, some clients require help in all of these services (Zastrow, 2000: 566).

A wide range of professionals is involved in rehabilitation for PWD. In most rehabilitation settings, a team approach is employed (Zastrow, 2000). Professionals that provide rehabilitation services include doctors, nurses, clinical psychologist, physical therapists, psychiatrists, occupational therapists, recreational therapists, hearing therapists, industrial art teachers, special education teachers, prosthetists, and social workers. Most of these therapists focus on the physical functioning of the clients. Social workers focus primarily on their social functioning (Zastrow, 2000: 566).

According to Zastrow (2000: 566), roles of social workers in rehabilitation for PWD are articulated in two general ways:

1. Social workers may be employed in settings that primarily serve PWD, such as rehabilitation centres, nursing homes, general hospitals, day-care centres for PWD, rehabilitation hospitals, and such specialized schools as schools for people with visual disability or intellectual disability.
2. Social workers encounter PWD in settings in which the primary service focus is something other than rehabilitation. For example, social workers at family counseling agencies usually see families with marital and interpersonal problems. One or more of these family members may have a disability. The

disability may be unrelated to the family problems, or it may be an important contributing factor. In the later case, the social worker's role is to help family assess and understand the nature and impact of the disability and the develop effective strategies for handling the difficulties associated with the disability.

In the context of Indonesia, Zastrow's classification is articulated in the systems and approaches of social work services. On the basis of specific characteristics of PWD, social work services and roles for PWD in the country can generally be put into practice with reference to three systems and approaches of services:

1. Institutional-based rehabilitation (IBR)

This service system of rehabilitation is especially provided for PWD who need special and intensive services for certain period of time in both governmental and non governmental agencies. It is estimated that at national, provincial and local levels, there are over 186 governmental organisations and 750 self-help organisations for PWD (APDC, 2006). Amongst others, YAKKUM is a well recognised non-profit organisation in Yogyakarta aimed at providing income earning opportunities for physically disabled young adults through the production and marketing of handicrafts (see Box 2).

2. Community-based Rehabilitation (CBR).

This non-institutional service system is based on the principles that the family, relatives, and local people are involved in the rehabilitation process of PWD and that their involvement can make a real difference to the mobility and comfort of PWD. CBR refers to an outreach project of community based rehabilitation to reach disabled people in their own communities. In this case, social workers help to ensure that PWD houses are accessible and that their communities are made aware of disability issues. There are several organisations which support CBR programmes throughout the country (APDC, 2006). One such program was launched in 1979 in cooperation with the Government, UNDP and ILO. The MOSA represents the Government in these initiatives and launched a series of projects on CBR focused on strengthening and developing CBR infrastructures and mechanisms at a grassroots level. The project established 4 CBR sheltered workshops and vocational training centers. By the end of 2000, there were 273 centers throughout Indonesia. A permanent training facility was established at the Prof. Dr. Soeharso Rehabilitation Center. The center emphasized the empowerment of small business entities of the disabled, through the provision of inexpensive and appropriate prosthetics for rural disabled people.

3. Residential Social Cottages or LIPOSOS (Lingkungan Pondok Sosial)

It is a system of social rehabilitation involving comprehensive and integrated rehabilitation services for all types of disabilities in one unit of social village or environment. This system can be referred to as an integrated non-institutional multi

service centre not only for PWD in a "true" meaning, but also for those categorised as socially and morally "abnormal" people such as vagrants, beggars, ex-prostitutes, ex-verdicts. This system is still under process of development but it is expected that this LOPOSOS can gradually to become an administrative village, especially for such programme outside Java. In Java, LIPOSOS generally serves as a centre providing mental, social and skill training for PWD to become productive people as well as a pre-conditional centre for PWD to be prepared and ready for transmigration.

Box 2: The Profile of YAKKUM

YAKKUM, Christian Foundation for Public Health, is a non-profit organization located in Yogyakarta, Central Java. YAKKUM Craft was established in 1991 and is the sister organization of Pusat Rehabilitasi YAKKUM, a rehabilitation center. The aim of the organization is to provide income earning opportunities to physically disabled young adults.

Over the last few years many young adults with physical disabilities have attended vocational training courses run by Pusat Rehabilitasi YAKKUM and learnt how to make handicrafts. At the conclusion of the training, those who achieve the required standard have become regular producers for YAKKUM Craft. YAKKUM Craft markets quality handicrafts made by growing teams of producers under the "RehabCraft Label". YAKKUM Craft currently has a total of 147 producers all with physical disabilities, 42 producers work on site and are paid a monthly wage: 105 producers work at home and paid per item made; 56 percent of producers are men and 44 percent are women. Special benefits for producers include medical expenses, transportation allowance and accommodation allowance. The legal document, which established YAKKUM Craft, requires that 90 percent of the producers and 60 percent of the administrative staff must be disabled. In fact at present, 100% of the producers and 76 percent of the staff have physical disabilities.

Source: YAKKUM (http://www.expat.or.id/givingback/yakkumcraft.html)

In Indonesia, roles of social workers working in rehabilitations settings are generally dealing with a number of tasks such as providing motivation and psychosocial diagnose; physical, mental and social guidance; vocational training; supportive therapy; re-socialisation guidance; small business training; and follow-up interventions (MOSA, 2003b). Examples of programmes for PWD in which social workers are involved include direct- and indirect-interventions, such as psychosocial therapies; the establishment of workshop and training programmes for promoting

income generating activities, productive entrepreneurship groups; the organisation and development of mobile rehabilitation unit, income maintenance and social assistance schemes, employment opportunity creations, and social and cultural activities.

Seven major functions of social workers in rehabilitations settings outlined by Zastrow (2000: 567-571) help further to understand social workers' roles in working with PWD:

1. **Counseling clients**. Social workers provide counseling to PWD to help them to adjust to their disability and to the rehabilitation programmes at the agency. In this context counseling usually involves a wide range of problems such as personal, interpersonal, family, financial, vocational adjustment, and educational adjustment.
2. **Counseling families**. In some situations, social workers do not always provide counseling to PWD directly, especially if the PWD is a young child. Instead, social workers provide counseling to the family of PWD, including their "significant others" such as siblings, peers and relatives. Working with the family is initiated to helping them to understand the nature of the disability and the prognosis, to make the essential adjustments to help the PWD, and to deal with personal and interpersonal concerns associated with the disability.
3. **Taking social histories**. A social history essentially comprises information about the PWD's family background and present socio-economic status. Information for the social history is collected from a wide range informants such as the PWD and family members. The data can be gathered too from case records of other social and medical agencies that the PWD has had contact with. A social history usually covers data on what the PWD's family life was like before contact with the agency, what it is like now, and what it will probably be like in the future. It also contains a history of the disability, positive and negative reactions of family members to the disability, significant family relationships, a summary of strengths and weaknesses within the family in dealing with the disability, information on social skills of the PWD, a history of PWD's functioning at school and at work, a history of services provided in the past, and a summary of the problems associated with the disability and concerns of family members (an example of social history is attached in appendix).
4. **Serving as case manager**. PWD frequently require extensive services and resources, including those provided by systems of health care, mental health, education, housing, employment, and other related systems. Due to the pervasive needs of PWD, it is important that one of the service providers, typically a social worker, be designated as a case manager. In this context, a social worker coordinates needed services provided by a number of agencies, organisations, or facilities to PWD. Such a role assigns responsibility for planning and organising the delivery of services in a systematic and timely manner.

5. **Serving as liaison between the family and the agency**. In a rehabilitation setting, social workers can serve as liaison between the agency staff and the family. In this case, a social worker may arrange meetings between the staff and the family to discuss disability conditions of PWD, factors affecting rehabilitation, and required future plans and services. In a hospital setting, for example, a doctor is responsible to explain the particular medical condition to the PWD, but implications of the medical condition with the PWD and the family is part of a social worker's responsibility. Implications of the medical condition may include the effect of disability in the future on the capacity of the affected PWD in terms of their functions at school, at work, in social situation, and within the family. As a liaison, social workers need to have basic knowledge pertaining to a variety of medical conditions and terminology as well as an awareness of the implications of these medical conditions for emotional, physical, and social functioning.
6. **Being a broker**. PWD often need a variety of services from other community agencies, such as financial assistance, wheelchairs, prosthetic services, daycare services, special job training, visiting nurse services, and transportation. A broker role refers to functions of linking families with other community resources. To perform this role, a social worker should have knowledge of different types of community resources and services, including the programmes provided, eligibility requirements, and admission procedures.
7. **Doing discharge planning**. Social workers usually help PWD and their families prepare for returning to the home or to some other facilities. Discharge planning is especially vital in some rehabilitation settings, such as hospitals. In a case that a PWD cannot to return home, placement in some other setting must be arranged, such as in a nursing home or a group home. In this case, arrangements must be made for financial aid and for such specialized care as home health care, daycare, physical therapy, and job training.

THE PROCESS OF SOCIAL WORK SERVICES

MOSA (2003b: 64-65) provide guidelines of social work process in rehabilitation settings to include seven stages: preliminary contact, problems assessment, planning for services rehabilitation, implementation, re-socialisation, follow-up, and termination. As indicated above, to be effective it is suggested that the process of social work intervention needs to consider empowerment-based social work perspective.

DuBois and Miley (2005) assert that in empowerment-oriented processes, social workers and PWD set out their work together as collaborative partners, because for PWD, collaboration actualizes empowerment. On the basis of empowerment paradigm which focuses on the strengths perspective the process of social work services in rehabilitation settings may follow nine stages (DuBois and Miley, 2005: 199-224):

1. **Forming partnerships**. This stage is basically aimed at building empowering social worker-PWD relationships that acknowledge PWD's privileges and respect uniqueness. In this initial step, social workers must respect PWD's perspectives and recognise the positive contribution of working collaboratively. Factors influencing positive relationships include social workers' professional purpose, the nature of PWD's participation, and social workers interpersonal skills, such as empathy, warmth, genuineness, and cultural competence.
2. **Articulating situations**. A PWD seeks for social work services for a reason relating to a problem, issue, or need that the PWD wants to overcome. Articulating situation is a process developed by social workers through their dialogue with PWD about the reasons motivating PWD to seek assistance. This stage involves an assessment to identify challenging situations by responding to validate PWD's experiences, adding transactional dimensions, and looking toward goals.
3. **Defining directions**. Social workers and PWD need to have some directions for their collaborative efforts. In this process, social workers and PWD clarify the preliminary purposes for their working relationship and respond forthrightly to preemptive crises. Defining directions are geared to determine a preliminary purpose for the relationship to activate motivation and guide the exploration for relevant resources.
4. **Identifying strengths**. Identifying PWD's strengths and resources enables to strengthen PWD potential and initiatives for change. At this stage, efforts are usually emphasised on searching for strengths in general functioning, coping with challenging situations, cultural identities, and overcoming adversities. The possible strengths include available resources, adaptability to changes, cultural strengths, distinctive characteristics, alliances, and outstanding qualities.
5. **Assessing resource capabilities.** This is the dynamic process of gathering and exploring information in order to understand PWD's challenges. Social workers and PWD are working together to explore the particulars of the situation, the potential effects, and the resources necessary for implementing solutions and executing planned actions. This step may involve the exploration of resource capabilities in transactions with the environment including connections to family, social groups, organisations, and community institutions.
6. **Framing solutions**. In framing and developing solutions, social workers and PWD draw upon each other's knowledge, skills, and resources. This step focuses on constructing a plan of action that utilizes PWD and environmental resources and leads toward desired goals and objectives.
7. **Implementing action plans**. In general, this implementation process involves three core activities: (a) activating and mobilizing resources; (b) creating alliances amongst PWD, within PWD's natural support networks, and within the service delivery system; and (c) expanding new opportunities and

resources through programme development, community organising, and social action.

8. **Recognising success**. Evaluating the success of the change efforts are made to recognise achievements and inform continuing actions. The focus attention of this stage is to respond to such questions as have PWD achieved their goals? Has the action plan made a difference? Have social workers and PWD focused on strengths, and have their activities empowered change? Are strategies effective and efficient?
9. **Integrating gains**. Integrating gains enable PWD and social workers to have opportunities to benefit by integrating what they have learned into their bases of knowledge and storehouse of strategies for future actions. This ending change process is mainly intended to celebrate success, stabilise positive changes, and provide a platform for future changes. The success of the whole process of planned changes depend on the nature of its ending. Effective endings provide springboards to the future by recognising achievements, consolidating gains, and building a sense of competence. However, defining the ending of the social work process does not mean to ignore the fact that change is an ongoing process that continues after the professional relationship between PWD and social workers end.

CONCLUDING REMARKS

This paper has examined a number of issues and challenges in rehabilitation settings for PWD, including the roles of social workers and the process of social work services. In discussing and examining the themes of rehabilitation for PWD in Indonesia, attention has been placed not only on *das solen* or aspects of "what it is" and "what happen", but also on *das sein* or aspects of "what should be done" and "what can be done". It is expected that by providing theoretical and practical perspectives in dealing and working with PWD, participants of this training can learn from the existing conditions in Indonesian as well as from generated models and approaches that are useful for future reference of actions in their respective countries.

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