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Chapter 1 : Casey review raises alarm over social integration in the UK | World news | The Guardian

Community integration programs involve a team approach that can include the client, family members and caregivers, community members, health care and educational professionals, community organization staff, and governmental agency staff, among others.

This article has been cited by other articles in PMC. Abstract Objectives To determine whether a lifestyle integrated approach to balance and strength training is effective in reducing the rate of falls in older, high risk people living at home. Design Three arm, randomised parallel trial; assessments at baseline and after six and 12 months. Randomisation done by computer generated random blocks, stratified by sex and fall history and concealed by an independent secure website. Setting Residents in metropolitan Sydney, Australia. Exclusion criteria were moderate to severe cognitive problems, inability to ambulate independently, neurological conditions that severely influenced gait and mobility, resident in a nursing home or hostel, or any unstable or terminal illness that would affect ability to do exercises. Interventions Three home based interventions: LiFE and structured groups received five sessions with two booster visits and two phone calls; controls received three home visits and six phone calls. Assessments made at baseline and after six and 12 months. Main outcome measures Primary measure: The overall incidence of falls in the LiFE programme was 1. Static balance on an eight level hierarchy scale, ankle strength, function, and participation were significantly better in the LiFE group than in controls. LiFE and structured groups had a significant and moderate improvement in dynamic balance, compared with controls. Conclusions The LiFE programme provides an alternative to traditional exercise to consider for fall prevention. Functional based exercise should be a focus for interventions to protect older, high risk people from falling and to improve and maintain functional capacity. Introduction Falling in older age has debilitating and isolating social consequences, along with high and escalating economic costs. Fall related admissions have not declined over the past ten years, 3 and there is an imperative to develop effective strategies for fall prevention that are acceptable and sustainable over the long term for older people. The optimum exercise modality for falls prevention in older adults has been defined as balance enhancing activity and lower limb resistance training. Those people older than 70 years who do engage in balance and resistance training are much more likely to be healthy and functionally capable than those who do not. Integration of exercise into lifestyle activities could enhance exercise adoption and adherence in other cohorts, 6 7 8 but this approach has never been investigated in frail, older people at risk for falls. Therefore, we designed and tested the Lifestyle integrated Functional Exercise LiFE programme, which embeds balance and lower limb strength training into habitual daily routines. In a small pilot study, 9 this alternate approach to traditional exercise had high potential to reduce falls incidence rate ratio 0. We hypothesised that a lifestyle integrated approach using the LiFE programme to balance and strength training would be more effective than a sham control programme comprising of gentle exercise in reducing falls in high risk people aged 70 years and over and living at home over one year. We further hypothesised that a traditional structured exercise programme would be as effective as LiFE in reducing falls, compared with the control programme; that intermediate outcomes of strength, balance, functional capacity, and quality of life would show equal benefit in LiFE participants compared with the structured programme; and that balance confidence in daily tasks and habitual physical activity levels would improve to a greater extent from the LiFE programme than from either the traditional or the control programme. Methods Trial design We conducted a three arm, randomised parallel trial with assessments measured at baseline, six months, and 12 months after randomisation. The study was approved by the University of Sydney human research ethics committee and registered on 20 January DVA databases included veterans, their spouses, and war widows. Inclusion criteria were men and women aged 70 years or older and who had two or more falls or one injurious fall in the past 12 months, which was determined by self report. Randomisation was generated by an investigator not involved in data collection or intervention, who used Stata 7 and the add on program Ralloc 10 to generate random block

groups of three and six, and stratified by sex and history of fall that is, one or two falls, or three or more falls in a 1: The randomisation was conducted after baseline assessment and concealed by using an automated secure website that was operated by an off-site independent service. All assessments at six and 12 month follow-up, conducted on a home visit, and fall event surveillance were conducted by a research assistant blinded to group allocation. All data was also entered and checked by a blinded research assistant. Interventions In the LiFE approach, movements specifically prescribed to improve balance or increase strength are embedded within everyday activities, so that the movements can be done multiple times during the day. Rather than a prescribed set of exercises conducted several times a week, LiFE activities occur whenever the opportunity arises during the day. The LiFE training focuses on instituting new habitual behaviours within selected situational contexts that serve as prompts for action. We used an assessment tool designed for this study to establish the difficulty level of the strategy incorporated into everyday activity. Participants manuals provide examples of each balance and strength strategy across a range of daily activities and situations, with ideas for increasing intensity and challenge. The structured programme 14 involved seven exercises for balance and six for lower limb strength using ankle cuff weights and performed three times a week. The LiFE and structured programmes were taught over five sessions with two booster sessions and two follow-up phone calls over a six month period. Both programmes were prescribed, tailored, and upgraded. Ample evidence from home based structured programmes indicates that this dosage is feasible and cost effective. Exercises were not upgradedâ€”that is, not altered in any way such as changing the number of repetitions or increasing the challenge to balance. The reduced time given to the control intervention was appropriate because this programme was much simpler and easier to teach. Interventionists, trained in each of the interventions, included physiotherapists and occupational therapists. Outcome measures Fall surveillance A fall was defined as a person unintentionally coming to rest on the ground, floor, or other lower level. Falls were recorded by daily calendar, which were mailed monthly using preaddressed envelopes. A research assistant blinded to group allocation telephoned participants if they failed to return the calendar to ascertain whether they had fallen. Exercise adherence was monitored by weekly logs returned monthly by post to the interventionists once weekly visits ceased. Balance and strength Postural control was defined as either static balance where balance is measured in a standing position or dynamic balance where postural control is challenged during movement involving walking. Static balance was assessed using two hierarchical balance scales. We developed the second scale before analysis by using Rasch modelling 17 to test the ordering of responses, which required the collapsing of several higher level items to construct the eight hierarchy levels. Dynamic balance was measured by a 3 m tandem walk time and errors. Maximal isometric lower limb strength was determined by the highest of three measurements obtained using a Chatillon DMG dynamometer with a custom made portable stand to eliminate variability in examiner strength. Bioelectrical impedance analysis 26 measured body composition fat free mass using an Impedimed DF50 device on the right wrist and ankle and with the person supine on a bed. Statistical analysis We compared the rates of falls in the LiFE and structured interventions with those from the control intervention that is, gentle exercise using the negative binomial regression model Stata, version We monitored fall events for one year or until the person withdrew from the study, was lost to follow-up, or died. For secondary outcomes, we used the general linear modelling, repeated measures procedure SPSS, version The reported F ratio is a measure of the variation between groups divided by the variation within groups. We aimed to establish whether the change in one intervention was significantly greater than the control group over the 12 month follow-upâ€”that is, if retrospective linear contrasts rather than quadratic contrasts were significant, which would indicate change over time rather than just a difference at one time point. We analysed rank order categorical data using a polynomial regression model. We used a one way analysis of variance with retrospective analysis, and subsequent t tests, to determine any differences. To establish exercise maintenance at 12 months, we examined adherence in the final 12th month of follow-up. The major reason for not including people in the trial was that they did not meet the inclusion criteria for previous multiple falls in the past year or an injurious fall Other reasons were

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that participants were unable to independently ambulate 8. The sample recruited mean age Open in a separate window Flow chart of trial participants.

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Chapter 2 : 12 Ways to Promote Integration in Your Community | CLINIC

It should define the process of integration as "open" within the rules of liberal democratic societies, leaving room for an outcome of a society that is more diverse, but still cohesive. The diversity achieved in this way is neither predetermined nor static, but negotiated, shared, and ever-changing.

Theory[edit] Theorists have differentiated types and levels of integration in special education as physical, functional, social, community and organizational. Education[edit] Educational integration has a long history of debate described as "more comprehensive than academic mainstreaming. Board of Education, school integration was based on the right to a free, appropriate education in regular schools and classrooms. Housing[edit] In the US disability field a major shift has occurred from group and facility-based models to homes with support services, [34] emphasizing a change from "home-like" housing to community homes, neighborhoods and relationships. For example, in Great Britain community opportunities were sought so people could belong, contribute and make friends. Car-related examples include an amusement-park car track; car shows, bike nights and car cruise-ins, and model car racing. For those with severe disabilities employment-integration initiatives were often framed as supported employment , which allowed jobs at regular businesses and employment sites. A major success was the passage of the Americans with Disabilities Act of , amended in following the Rehabilitation Act of , amended in , which provided protection for men and women with disabilities in obtaining jobs, careers and positions with necessary workplace accommodations. Competitive employment integration at the US workplace is expected by law, and categorical services have tended to be developed as segregated bases e. Employment integration is a worldwide issue, modified by approaches to multicultural groups e. Policies[edit] Community integration has been most criticized for its inattention to gender, ethnic, cultural, racial, class and economic factors [79] [80] "double discrimination", pp. At the university level multiculturalism, including disability, was proposed as the solution to these complex issues. In the field of mental health Paul Carling promoted community integration in the s and s in opposition to the predominant medical model, [97] [98] while psychiatric rehabilitation also linked to the medical, often allied health, professions. Charlie Lakin [] The federal departments subsequently offered contracts to evaluate the status of these new community services in the US. The principles of community integration through the national flagship centers the Rehabilitation Research and Training Centers on Family and Community Living, [] facilitated by Lakin and J. Racino of Syracuse University were: All people with disabilities will be able to live successfully in and as part of natural communities that provide them the supports they need. All people with disabilities will be recognized for the positive contributions they make to their families and communities. All people with disabilities will benefit from enduring relationships with other people including family members and community members without disabilities. All people with disabilities and their family members will be entitled to participate in decisions affecting the nature and quality of services they receive. All people with disabilities will have access to services and supports that provide choice and support full citizenship. Services and supports for people with disabilities will be individualized and responsive to cultural and ethnic differences, economic resources and life circumstances. Public policy will provide thee opportunity to enjoy productive, integrated lives. Taylor, director; Julie Ann Racino, deputy director and B. Shoultz, information coordinator , held in Washington, D. Charlie Lakin, Ann P. By the late s, the Centers were renamed to Community Participation, one aspect of community integration, or to Employment, or other priority areas, such as Health, with many of the above centers still federally funded through the NIDRR program National Institute on Rehabilitation Research and Rehabilitation , US Department of Education and new academic centers at universities such as Temple University in Pennsylvania. Principles and practices[edit] In particular, community integration in intellectual, "severe" disabilities and developmental disabilities means families for all children. Community integration has been tied to quality assurance in the community and an improved quality of life. Internationally, research began on the "first integrated generation" in countries such as Sweden

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[] and integration was confirmed as a legal principle in the US. New book based on these principles is "Public Administration and Disability: Community Support for All". Priorities for people with intellectual disabilities in implementing the UN Convention on the rights of people with disabilities: Equity, Opportunity and Inclusion. If mainstreaming is the answer, what is the question? A Research Perspective" pp. A proposed new term for the principle of normalization. The basis and logic of the normalization principle. Stockholm College of Health and Caring Sciences. Community Support for All. Toward Universal Approaches to Support. Foundations for Educational Practice. Caught in the continuum: A critical analysis of the least restrictive environment. Creating change in states, agencies and communities. A Mandate for Change on Many Levels. The return to community. American Journal of Community Psychology, 17 1: All students belong in the classroom: Educational and residential placement issues. Parents, Educators and Inclusive Educators". Where there is a way, there is not always a will: Technology, public policy, and the school integration of children who are technology-assisted. Past, present and future. Feature issue on post secondary education and students with intellectual, developmental and other disabilities. Choices and Strategies for Adults with Disabilities. Homes, neighborhoods and personal connections. Factors in mortgage decisions. Hypersegregation in US metropolitan areas: Black and hispanic segregation along five dimensions. Assisted housing and residential segregation: The role of race and ethnicity in the siting of assisted housing developments. The effect of residential segregation on black social and economic well-being, "Social Forces", 66, The Influence of Local Leaders. State University at Albany. Social change in six Canadian inner cities, The politics of the neighborhood movement. South Atlantic Urban Studies, 4: Madison Mutual Housing Association. People caring about people. The Prairie Housing Cooperative. Confronting concentrated poverty with a mixed income strategy. The role of nonprofit housing in Canada and the United States: Housing Policy Debate, 4 1: The State of Housing in America in the 21st Century: President and Fellows of Harvard University. Toward inclusive, equitable and sustainable communities. Public Administration and Disability: Community Services Administration in the US. Toward Universal Approaches to Support". Access and inclusion to community leisure services. Places and Ways to Integrate". Deinstitutionalization and the role of therapeutic recreationists in social integration. Developing opportunities for an ordinary community life. Inclusion of older adults with mental retardation in leisure opportunities. The kid from Cabin Supporting children into integrated recreation. Rehabilitation Research and Training Center. Modifying rules of a regular girls softball league to facilitate the inclusion of a child with severe disabilities. Eds , The Variety of Community Experiences: Qualitative Studies of Family and Community Life". Community and Policy Studies. Securing Satisfying Careers for People with Disabilities. Reconceptualizing job coach roles. Vocational rehabilitation and traumatic brain injury: A legislative and public policy perspective. Issues in Law, Public Policy and Research. Workplace personal assistance services for people with disabilities: Making productive employment possible.

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Chapter 3 : About integrations - PureCloud Resource Center

relative to other Articles within the EEC Treaty system. Article 2 of the Treaty 5 lists the general tasks of the Community as: promoting a harmonious development of economic activities.

Received Dec 15; Accepted Jun This article has been cited by other articles in PMC. Abstract The practice of traditional Aboriginal medicine within Australia is at risk of being lost due to the impact of colonisation. Displacement of people from traditional lands as well as changes in family structures affecting passing on of cultural knowledge are two major examples of this impact. Prior to colonisation traditional forms of healing, such as the use of traditional healers, healing songs and bush medicines were the only source of primary health care. It is unclear to what extent traditional medical practice remains in Australia in within the primary health care setting, and how this practice sits alongside the current biomedical health care model. An extensive literature search was performed from a wide range of literature sources in attempt to identify and examine both qualitatively and quantitatively traditional medicine practices within Aboriginal Australia today. Whilst there is a lack of academic literature and research on this subject the literature found suggests that traditional medicine practice in Aboriginal Australia still remains and the extent to which it is practiced varies widely amongst communities across Australia. This variation was found to depend on association with culture and beliefs about disease causation, type of illness presenting, success of biomedical treatment, and accessibility to traditional healers and bush medicines. Traditional medicine practices were found to be used sequentially, compartmentally and concurrently with biomedical healthcare. Understanding more clearly the role of traditional medicine practice, as well as looking to improve and support integrative and governance models for traditional medicine practice, could have a positive impact on primary health care outcomes for Aboriginal Australia. This worldview recognises good health as a complex system involving interconnectedness with the land, recognition of spirit and ancestry, and social, mental, physical and emotional wellbeing both of the individual and the community [2]. Indigenous Australians view ill health as the result of one of three causes â€" a natural physical cause, a spirit causing harm, or sickness due to sorcery [3]. The impact of colonisation and the subsequent displacement and disconnection of people both from their traditional lands and later from their traditional families has been significant in its subsequent effect in the use of traditional practices including traditional medicine [4]. The Alma-Ata declaration on primary health care PHC by the World Health Organization WHO in witnessed a response from several countries to improve their traditional medicine use and regulation of use within the primary health care model. This holistic approach in the evolvement from primary medical care to primary health care as adopted by the Alma-Ata declaration in has been praised, however there has been no mention of the incorporation of traditional medicine use within the design of these health services as other countries have [6]. It is acknowledged that in remote areas in other countries it is common for traditional medicine to coexist with biomedical healthcare as part of a pluralistic medical system [7]. It is unclear if this also applies to Aboriginal Australia and if so, to what extent traditional medicine is practiced and how it sits with the use of biomedical healthcare. Treatment modalities within TMP for the review will be inclusive of Traditional Healers TH , herbal medicines, ceremonies and healing songs [8]. Whilst it is recognised that bush foods also play a role in traditional health practices, specific articles on bush tucker and nutrition will not be included due to the limitations on the length of this review. Methodology Database searches were performed via the internet using Google, Google scholar, PubMed, Indigenous health info net, snowballing reference citation , related government and non-government websites. Keywords used in the search were: State library resources were also identified. Literature included in the review either; i. Documented any TMP amongst communities including the type of ailments treated. Literature excluded from the review either; i. Examined the biological activity or phytochemical constituents of medicinal plants identified; iii. TMP was not at the primary health care level. Examined non-Indigenous Australian models of TM i. The total number of articles found that met inclusion criteria was 13, dating from

â€” The review was conducted solely by the publishing author. Key findings The review is themed according to the setting of PHC. The first group is PHC based at an established health clinic with two sub-groups â€” clinics offering any aspect of TMP alone or in combination with biomedical health care, and clinics offering only biomedical health care. Questionnaires were distributed to all participating Aboriginal and Torres Strait Islander biomedical health services that receive funding from OATSIH for provision of primary health care. The results showed that in the year â€” the percentage of health clinics that offered services of traditional healers was This compares with previous years â€” â€” at Therefore statistically within government funded established primary health care clinics in Aboriginal Australia roughly one fifth offer traditional healers and one tenth offer bush medicines as part of the healthcare service. There is however a lack of detail within the report surrounding this service provision. Details such as how often these services were provided, when, why and how they were provided with respect to biomedical healthcare and if these service provisions resulted in employment within the health service were not reported. However there were written anecdotal reports from Aboriginal health workers and nurses employed within select health clinics for the storage and use of bush medicines, and sometimes THs, within the clinic [10 , 11]. Observation of a TH visiting to the clinic i. These anecdotal accounts give us little information regarding the extent of use or the reasons for use of TM, and are unreliable as sources of current practice as all three accounts were written 9 years or more ago. The Akeyulerre Healing Centre in Alice Springs offers stand-alone TMP THs and bush medicines in a culturally safe place where traditional knowledge and practices can be shared and practiced. An Australian Broadcasting Network ABC interview conducted with an ethnobotanist researching the use of bush medicines and a local elder women discussed the use of specific bush medicines made by local community people provided at the centre [14]. Similar to Alice Springs local elder women in the Western Australian Kutjungka community Balgo Hills Wirrimanu have formed the Palyalatju Maparna Health Committee which provides bush medicines to the local biomedical health clinic at Balgo, the local community and surrounding communities [15]. In April the funding was ceased and the committee dissolved [16]a. The incorporation of the Palyalatju Maparna Health Committee could be seen to play an important role in the community for access to bush medicines for primary health care. Whilst further research is justified in assessing this role both qualitatively and quantitatively the article does give us an indication that the provision of bush medicines by local women elders improved TMP for the Balgo community. Clinics offering only biomedicine A qualitative survey by way of a questionnaire was developed in Aurukun Health clinic, Cape York Peninsula in far North Queensland, to determine the extent of use of bush medicines by clients of the health service and for what types of illnesses medicines were used for [18]. Permission for the survey was gained from the Queensland Health Ethics committee and the survey was conducted and filled in by clinic staff due to low literacy levels of clients. As a consequence the survey did not go well and no understanding of bush medicine use was gained as a result. The set up of this survey could be seen to fail on several levels â€” identification of some of these reasons has been made by reviewers of the research project [18]. Cross-cultural communication, cultural sensitivities for sharing of knowledge and re-enforcing of negative colonialist experiences through the research process were reasons identified. This highlights difficulties in qualitative field research, and the need for sound cultural understanding and putting time into the design of research and building trust relationships with community before attempting research. Both a book has been published about these traditional healers, or Ngangkari [20], and an interview was recorded on ABC which examined the role of the THs [19]. It is reported that Ngangkari work hand in hand with the mainstream health services both in primary and tertiary health care and are recognised by the mainstream medical doctors, working alongside and in co-operation with them. This doctor then refers to the TH for a treatment who then refers back to the western doctor for pharmaceutical medicine rather than traditional herbal medicine. No information is given surrounding this process that informs the reader of the extent of this practice, such as was it the western doctor who felt that the patient would benefit from the TH, is this process used on every patient or was it at the patients request? What we can determine from this account is that there is mutual respect between the western doctor and TH in this

situation. The account sought to understand by way of this observation as well as conversation with community members about health behaviour after their permission was sought. Observational reports stated that many people visit the Maparn first, especially if they consider their sickness to be serious, and that sometimes Maparn will visit the clinic, especially if a family member requests their presence. An account of a young man in his twenties who used services of both the Maparn and the health clinic concurrently was described â€" the young man would visit the Maparn in the morning and the clinic in the afternoon. The availability of Maparn may affect the role that TM plays â€" in some communities Maparn have passed on and in others they have given up their practice, which means that Maparn from other communities will need to travel. Although this type of research provides detailed and accurate description, it does lack objectivity and does not give us a reliable indication to the extent that Maparn are incorporated in health behaviour of the community, for example a percentage of community members that use Maparn, and if this use is associated with cultural affiliation. In his observations the author discovered that the use of bush medicine was used to treat specific symptoms of illnesses and included coughs, colds, wounds and sores, and that every adult and many children had some knowledge of bush medicine. If the disease however was caused by sorcery then an Ngangkari was consulted. Two illness-related cases were followed to examine health behaviour. The first case was a 44yr old male who consulted several Ngangkari over a period of weeks before finally visiting the clinic biomedical after his condition was not improving and becoming worse. The second case was a 33yr old girl who after years of biomedical healthcare ceased visiting the clinic except to collect her long-term medicines to engage with an Ngangkari. These two cases give an example of different age and gender who both utilised THs in different sequences, and whilst the same subjectivity may apply as for the above ethnographic study and lack of understanding of the level of the community who engage with Ngangkari, it does give us an indication of the role of the TH based on health beliefs of illness causes. The qualitative analysis was by way of individual in-depth interviews, observations and field notes. Results were analysed thematically into reasons why or why not bush medicine was used demonstrating both the role and use of TM. Consent was given from the Aboriginal reference group involved and this group was consulted throughout the study period. Thirty seven in-depth open-ended interviews were conducted in English, including one rural and two remote participants whilst the remainder resided in urban Perth, Western Australia. Out of these 11 types of cancer were identified and only 11 of the 37 interviews were used as the focus for the paper. The results of the study found that bush medicine played a role in symptom relief from chemotherapy or stress associated with the situation. In some cases people chose TM over western medicines and vice versa depending on their situation and beliefs surrounding chemotherapy and TM. Such situations were likely to be concern over leaving family to come for chemotherapy treatment, adverse reactions from chemotherapy, limited access and knowledge of bush medicines, and uncertainty about bush medicine interactions with cancer medicine [23]. Although evidence exists for the use of TMP in primary health care, either alone or in combination with biomedicine, reliable and valid research is lacking. Specifically, there is a paucity of literature that seeks to examine the role of traditional treatment modalities of ceremony and healing songs, instead the focus is on traditional healers or bush medicines. Saying this, the literature found does give us an indication that TMP exists and this enables a discussion about its role in PHC. The percentages of overall service provision serves as a useful tool to examine the extent of TMP. Combining both THs and bush medicine gives us a figure of Quantitatively this report gives us no indication for reasons and extent of use of these services within an individual clinic, such as how often or what type of illness. More questions need to be designed into the report if these reasons are to be identified and examined. Qualitatively, the role of TMP can be described as sequential i. The ethnographic research conducted [21 , 22] show that people within the relevant communities studied exhibit all 3 types of health behaviour for using THs. This behaviour could be affected by the residency or employment status of the TH within the health services. It is reported that THs were employed in Australia by the Northern Territory Department of Health in the early s, however a training course to teach traditional healers about western medical practices was soon replaced by the training program for AHWs [24]. Within the context of primary

health care, they can blend together in a beneficial harmony, using the best features of each system, and compensating for certain weaknesses in each. While not articulated in any of the research, the area of uncertainty for drug-plant interactions should be considered from the other perspective also â€" that is non-compliance of pharmaceutical medicine due to a desire to use bush medicine and not wanting to mix the two. We can see with a clear mind. Integration of both systems requires an understanding of the social and cultural constructions of each medical system and the complexity of the whole. Because we are not traditional Aboriginal, and our family was Christian based, and soâ€¦We put our trust on God. A perceived failure of treatment would then impact on the role and health-seeking behaviour of people, especially for illnesses where pharmaceutical medicine is being used to treat in a preventative role, such as the prevention of micro- and macro-vascular complications of diabetes type 2. Another influence that has been identified in the above review is that of gender. The Maparn THs in the Kutjungka were reported to be generally male, although there are some female Maparn. The resultant effect was for these women to not access the biomedical healthcare and treat their children at home with TM. This highlights the importance to incorporate gender roles within research for TMP.

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Chapter 4 : OHCHR | Convention on the Rights of the Child

Managing a multi-player community of renewable consumers and producers successfully Utility and public interest in renewable integration within distribution networks has rapidly risen in popularity. For the public, general sentiments.

This new report is a revision of the original report produced with Corporation support. The Integration of Immigrants into American Society summarizes the findings of new research on how immigrants and their descendants adapt to American society in a range of areas such as education, occupations, health, and language. The report found that immigrants began to resemble native born Americans over time. As they and their descendants mix into U. However, there can be declines in wellbeing in the areas of health, crime, and family patterns. Read the interview with National Academies of Sciences author Marisa Gerstein Pineau and panel member Richard Alba about the findings revealed in the report: What effect does the current immigration system have on integration? I think what the report documents is really the power of the integration processes in American society. The really big headline is that despite the difference in the sourcesâ€"the national sources of immigration today as compared to years agoâ€" immigrants and their descendants on the whole are integrating into American society at a pace that is consistent with our historical experience, and I think that holds for the people who are coming today. In fact, the number of Asians coming is now higher than in the past, and we know that the Asian groups are integrating very rapidly into American society. Marisa Gerstein Pineau MP: The other potential barrier, and this more nebulous but we talk about it a in the report, is that you face different barriers based on where you live. Integration happens in the specific localities where people settle, and especially with immigrants moving to new destinations, that can potentially create problems, particularly in places without a history of immigration. Not always; there are communities that are new destinations that are very welcoming. What are the most significant ways that immigrant populations today are different from those who have arrived earlier? There are two really important differences to keep in mind. The first is that the issue of legal status was a non-issue in the earlier great wave of immigration. And, historically, we can see that there were smaller numbers of the undocumented probably thought of as illegal back then , but they were treated in a very different way; much less harshly than today. There was no such thing as a temporary status in the early 20th Century. That has a real impact on how people integrate, and even on how their U. The second really big difference is that the current wave of immigrants includes a very large number of people with high levels of educational and professional qualification. This is true especially of the groups coming from Asia, such as the Indians or the Koreans. The other obvious difference is that the earlier waves were coming from Europe. They were ethnically different, and in some ways at the time considered racially different, but, they were generally considered white, or became considered white fairly quickly. Now most of the immigration is from Latin America and Asia. The report finds that it actually is not a barrier. The place where race does seem to present the biggest problem is for black immigrants, who often come with quite high levels of education and skills, but whose children and grandchildren appear to be integrating into the black native-born population instead of the native-born population. How do immigrants benefit by integrating into U. There are certainly some scholars who would argue that there can be benefits from remaining embedded within a kind of ethnic immigrant community matrix. But, on the whole, I would say immigrants and their children benefit because they gradually attain opportunities for participation in the wider society that are on a par with those of the native group. What are some of the key barriers to integration? One is that lack of permanent legal status impedes the integration process, and the evidence in the report shows that it impedes the integration, for example in educational terms, even of the U. The second barrier is a very low starting point. Third, race or ethnic status is to some extent a barrier. We do see disparities among the descendants according to their racial origin. The report acknowledges that this could also be true of Latinos, that they are exposed to some degree of discrimination in the later generations that continues to exert a kind of friction in terms of their integration. In what ways can immigrant

well-being decline as they converge with native-born Americans? Wellbeing does decline by the second and third generations. This is even the case with immigrants, to some extent, over the course of their lifetime, although they generally live longer and have better health. In the second and third generations you definitely see a rise in obesity, in chronic health problems, in cancer, in mental disorders, and in alcohol abuse. The mechanisms are still being investigated. The pressures of integratingâ€" discriminationâ€"might have something to do with it. But, a lot of research has pointed to alcohol use and poor diet. Plus limited access to health care in the case of children who are growing up in relatively poor immigrant families. This could also be an issue. And, insofar as they are growing up in families that are undocumented, and are therefore fearful to make use of the health care system, obviously there are health impacts. How are immigrant waves affecting the current U. The report emphasizes that integration is, generally speaking, a two-way process. Looking back on the last wave of European immigrants, you are better able to evaluate what their impacts were on American society. A few things are obvious. Food, is so obvious it hardly needs to be said. The American language has evolved in part by absorbing words and expressions from immigrant languages. Likewise, Spanish is having a big impact on the native population. Those languages are gone. Spanish is the prime language that we study. Immigrants and their children are having a tremendous impact on the mainstream society because they are integrating socially. There are the very high rates of intermarriage that we now see, and of mixed background children. A survey of the entire population found that today, one in three Americans says that he or she has a close relative of another race. Immigration, especially in smaller places and rural towns where immigrants move, is really changing the face of these communities. And in some cases, has essentially rescued them from dying. Also, more immigrants now move to the suburbs than to central cities. It used to be that people would move to Chicago, and L. Americans generally have very positive attitudes towards immigration.

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Chapter 5 : Integration | mathematics | www.nxgvision.com

Integration happens most successfully at the local level. Positive day to day interactions between local residents encourage mutual understanding of different perspectives and lead to increased respect amongst all those calling a community home.

Advanced Search Abstract In the rural context, community development is considered to be a primary component of effective and sustainable social work practice. Yet there is little research into how rural social workers integrate community development values, skills and strategies into their practice. This exploratory qualitative study of rural social workers in Victoria, Australia, found that they utilized community development approaches in a diverse range of ways. However, they were constrained by the limited and inconsistent formal support to place community development within the continuum of social work practice. Introduction Community development approaches are widely understood by researchers, scholars and practitioners to be fundamental to effective social work practice, particularly in rural areas Collier, ; Martinez-Brawley, ; Cheers, ; Lonne and Cheers, ; Locke and Winship, ; Mason, ; Aimers and Walker, ; Filliponi, Despite this, Australian social work is overwhelmingly focused on individuals, families and groups Mendes, Very few rural social workers identify themselves primarily as community workers Lonne and Cheers, , and few social work roles are constructed with explicit reference to community development methodology Mason, , For the purposes of this paper, the terms community development and community work are used interchangeably. The AASW recognizes the need for social workers to work with the person within the context of their social environment Australian Association of Social Workers, But community development is more than a discrete component of social work practice. Rather, community development can refer to various methods, approaches and philosophies that underpin a range of activities, and can be practised by various professions and non-professionals beyond social work practice Kenny, This article will refer to community development as a body of knowledge and practice that is both a separate discipline and also regarded by the social work profession as an integral element of holistic and effective practice. This bottom-up approach reflects a central value base of community development Ife, ; Kenny, Both social work and community development share a commitment to human well-being, and have social justice and human rights as core practice values Mendes, Where they differ is in their general orientation to micro or macro levels of engagement. For some, community development represents an alternative approach to social work with quite distinct practice aims and values â€" framed as a separate discipline focused on empowerment and structural change Kenny, Others believe that community development is integral to social work and that its sidelining within social work practice comes at the expense of holistic practice. This viewpoint suggests that closer integration of community development skills and strategies will benefit social work by enabling practitioners to help larger numbers of people than via individual casework alone, and adopt a more long-term and empowering approach Goldsworthy, ; Lynn, ; Mendes, Mining booms may provide greater employment in rural areas, but can also have adverse impacts on housing affordability and social cohesion Bay and Jenkins, Rural Australians experience disadvantage on a number of levels including poor access to health and education, limited work opportunities and low wages. They have access to fewer and less specialized human services and the resultant pressures manifest as social problems, with certain groups experiencing marginalization and social exclusion Chenoweth, ; Brown and Green, The geographic and structural disadvantage faced by rural communities is reflected in the practice challenges facing social workers such as limited resources, high workloads and complex networks of relationships Chenoweth, ; Alston, ; Mason, Effective workers tend to have wide-ranging knowledge of the members and networks in their communities. By being part of strong networks, workers can stay in touch with local needs, practices and emerging issues of the mainstream and minority groups Mason, ; Pugh and Cheers, Most rural social workers identify their primary role as case management Lonne and Cheers, , but rural social work practice tends to be generalist,

embracing both casework and community work as a pragmatic means of addressing the contextual circumstances Pugh and Cheers, Community development is a vital ingredient in rural practice for a number of reasons. Its grassroots approach focuses practice on harnessing existing local skills and resources and making do with limited service networks. It is aligned with the values of rural communities, where the self-help tradition is accorded more value than the institutional welfare system Briskman and Lynn, ; Chenoweth, Finally, dealing with community-wide entrenched intergenerational disadvantage solely at an individual level can be counterproductive Calma, Existing rural social work research Much Australian rural social work research has focused on developing an understanding of how rural practice is distinct from urban practice Puckett and Frederico, ; Green and Gregory, A few key themes are apparent from the research literature regarding the location of community development within contemporary rural social work practice. Firstly, community development is known to be a central and necessary strategy for effective practice in the rural context Alston, ; Mason, However, it also appears to be marginalized in practice. For example, a two-year longitudinal study of rural social workers found only 5. While this finding refers only to those who identified a practice method as their principal function rather than as one aspect of their practice, it could be argued that this reflects a general leaning towards individualistic social work practice models and roles Lonne and Cheers, Secondly, both embedded practice being known as a member of the community and generalist practice are shown to be appropriate social work approaches for effective rural practice, and both can be linked closely to the underlying principles and values of community development Mason, Finally, networking â€" the sharing and combining of resources, skills and knowledge across organizations and throughout communities â€" is the community development practice approach that has been most consistently identified in research. For workers to function effectively within the complexity of small rural communities, they need to know and understand community dynamics, key players and resources, and facilitate and maintain strong networks Green, a ; Munn and Munn, To date, there has been no comprehensive exploration as to how rural social work practitioners use community development approaches in a practical sense within their daily activities. Nor has there been much research on how this is managed within the pressures of the contemporary rural practice context. This study examines how rural Victorian social workers construct, define and integrate community development practice values, skills and strategies within their core practice. Methodology This study was an exploratory research project, using qualitative semi-structured interviews with eight rural social work practitioners. The literature demonstrates that, despite widespread acceptance of the vital role and practice of community development within rural practice, there has been little research on the specific community development skills being used, or how rural social workers incorporate these skills into their daily practice. Given that little was known about this topic, an exploratory research design was chosen Alston and Bowles, to facilitate exploration of the undetermined characteristics of a new body of knowledge. A purposive sampling technique was used to explore the perspective of eight social workers who work in rural Victoria. Interested participants were invited by telephone or email to contact the researcher. Individuals were screened to confirm their self-identification as a rural practitioner, and the suitability of their practice location and sector, experience and core practice area for the study. Information about the research was provided to the participant, with a copy of the explanatory statement and consent form. Semi-structured interviews were conducted to facilitate deeper exploration of specific topics and themes of particular relevance to each participant. Interview topics included practitioner definitions of key terms such as community development, social work and rural practice, their background and experience as a rural social worker, the community development methods and strategies used, and the factors that influence how community development is incorporated into their practice. Also covered were the issues and barriers they face to using and integrating community development strategies, and the means by which they overcome these barriers to meet the needs of their clients and community. A coding process was employed to analyse the data, and identify key patterns, trends and explanations that responded to the research question Alston and Bowles, This methodology had some obvious limitations. The eight participants did not constitute a representative sample of rural social

workers in Victoria, and the study was not able to examine in any depth contextual influences such as demography, organizational factors and practitioner values that may affect the use and integration of community development values into rural social work practice. Profile of the interviewees The eight interviewees varied in experience from fifteen years as a social worker to only one and a half years. Their core roles included case management, counselling, generalist social work, mental health social work and management, with one holding a community development position. A number of participants held multiple different paid roles, with some also involved in volunteer projects. Some participants had done previous study prior to completing a social work degree. For example participant G had an extensive history of community work prior to studying social work. Five of the interviewees had only worked in rural practice, but three participants had experience working in metropolitan-based social work prior to their current roles. The practice locations included northern central, southern and central Victoria. There were no participants from far western or eastern Victoria. The types of practice location ranged from regional cities to small isolated towns. Four participants were based in towns between 50 and 70 km from the Melbourne CBD. Two participants were located in large rural cities, while two others were located outside regional cities and more than 80 km from the metropolitan fringe. The organizational context varied. One participant worked in a state-run health agency. Four participants were employed by community organizations receiving state or federal government funding. One worked for a church-based welfare organization.

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Community integration, while diversely defined, is a term encompassing the full participation of all people in community life. It has specifically referred to the.

An example of collaboration between a camp and a human service organization A sense of belonging: Integration in recreation and leisure-time activities Promoting inclusive recreation and leisure opportunities for adults Part III: Annotated Bibliography on Recreation and Leisure Opportunities Introduction Recreation and leisure activities are a critical dimension of the quality of life for all people, including those with developmental disabilities. There are a vehicle through which people have fun, meet new friends, and develop skills and competencies. Many people are still limited to segregated recreation and leisure choices. When other opportunities are offered, they often involve taking groupings of people with disabilities to large public settings e. While not all people with disabilities need support to participate in recreation and leisure activities, others, particularly those with more severe disabilities, may not have any access to integration recreation and leisure unless supports are available. At the same time, more community organizations and settings have opened their doors, in inclusive and supportive ways, to participants with disabilities. This information package highlights some of these efforts. It includes a brief overview of key issues in supporting people to be involved in integrated recreation and leisure, including: Finally, the packet contains an annotated bibliography. Some people will have had very limited opportunities to try a variety of activities in different settings with different people. Based upon past messages from professionals, families may worry that their son or daughter will have nothing in common with peers without disabilities. Some individuals with disabilities may have difficulty communicating ideas about potential interests. Thus, exploration of interests takes time, exploring and trying out different activities and settings. Interests link the personal and the social. They express individual gifts, concerns, and fascinations and call for activities, information, and tools. Shared interest founds associations. People point to interests when they describe what gives their lives meaning. This involves developing an interest to the extent that it becomes one of the primary defining characteristics of a person. This type of information can be gathered through means such as: Supporting People in Integrated Recreation and Leisure Activities In order to best assist people to participate in integrated settings, it may be necessary to provide some supports or accommodations. These supports should fit into the rhythms and routines of the setting or activity. Support can sometimes be provided by someone who is already present within a specific setting e. Related to this, it is important for this person providing support to involve him- or herself with others in the setting, not just the person with a disability. On this basis, he or she can act as a link through which others can get to know and interact with the person, as well. Collette Savard , pp. It becomes a vicious circle. Until Olivier builds close relationships with his peers he will need to be accompanied by adults, but while he is being accompanied by adults he is not likely to build close relationships with his peers. It is often these relationships that make leisure activities most meaningful. This may entail some level of bridgebuilding or facilitating; that is, intentionally creating and supporting social interactions between the person with disabilities and others. This may mean taking on new roles. For example, for human service agencies, it involves shifting away from operation of their own recreation program, to one of facilitating participation in community recreation and leisure activities and programs. For community agencies and organizations, it may involve: Conclusion With supports available to them, children and adults with severe developmental disabilities can choose to participate in a full range of community recreation and leisure activities based upon their personal interests and desires. The next section of this information packet contains a number of articles with examples of supports for inclusion. A final section contains an annotated bibliography of resources on integration recreation. References Center on Human Policy. A guide to knowing your community. How to find out about groups and organizations in your neighborhood. Using recreation activities to promote friendship between children with and without disabilities. Institute on Community Integration. Institute for Community

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Inclusion. The community leisure facilitator. What are we learning about bridge-building? Taking part in the dream. Allan Roeher Institute Ed. Enriching lives with people who have a disability pp. Community recreation and people with disabilities: Strategies for inclusion 2nd ed. Parents and professionals building inclusive recreation programs together. Community integration for persons with severe disabilities. Promoting inclusive recreation and leisure opportunities for adults. The kid from Cabin Involving students with disabilities in extracurricular activities at Levy Middle School. Center on Human Policy.

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These programmes perhaps lend some support to the effects of the integration component of the LiFE programme. 34 35 36 Dual tasking LiFE activities include a range of activities and can upgrade balance and strength challenges in small but incremental ways.