12/04/2021

Monday, April 12, 2021
12:02 PM

The insurance policies and documents related to them are completely focused on defining the "problem" of the disabled person and his or her need for medical supervision and treatment

In answering the questions 2-6, it is possible to go forever to see the circumstances that paved the way to the development of the DI policy. Need to set limits to how far I want to dig into the context of the policy and its introduction.

15/04/2021

Thursday, April 15, 2021
4:00 PM

After reading Britannia's history of Canada, notes issues related to indigenous and French, large impact on politics; note that any policy made usually ended having different impacts that intended;

19/04/2021

Monday, April 19, 2021
1:17 PM

While reading Contesting illness; it is interesting to note the quote "Complex workings of power spawn networks of experiences and actions that disrupt, deflect, or redirect anticipated or intended developments". This explains why despite the best "intent" of a policy, it does not have that effect and almost always unintended consequences. Reason why, as Foucault says, it is only possible to make changes at local levels

Also it is noted that Foucault feels power circulates through all aspects of one's location and relation in society, rather than from political institutions and structures

20/04/2021

Tuesday, April 20, 2021
8:58 AM

Reading contesting illness; Managing workplace depression: Contesting the Contours of Emerging Policy in the Workplace; Katherine Teghsoonean
I note the problem being either the individual or the workplace; however, the DM process makes the physician subservient to the insurer through defining disability as an economic cost (that can be solved through management or the insurer); defining disability in these terms provides the insurer to also

provide the solution, which is offered through DM, not through empowering the PM, but through ensuring compliance with the treatment process; the consumer is informed, but the alternatives available are tightly constrained by manager priorities;

Also, case management prioritizes early return to work to decreased costs of lengthy claims; having preferred providers ensures easy access to M.H professionals who are informed and cooperative in early RTW

10/05/2021

Monday, May 10, 2021
2:59 PM

Reading Disability Policy in Canada; Lyn Jongbloed PhD; associate professor in School of Rehabilitation Sciences, UBC; interest in interrelationships between disability and social

Law and order model 1900 cuz mentally disabled a threat;
Medical and economic models 1920-1970 individual medical and vocational limitations
Sociopolitical model 1970 - failure of social env't to adjust to the needs of people with disabilities

Author recommends mandatory affirmative action and contract compliance with federal contracts, an acknowledgement of the multidimensional nature of disability and need a normative foundation for analyzing the goals of respect, participation and accommodation to give consistent policy objectives (these 3 goals are based on Obstacles - a report by the Special Parliamentary Committee on the Disabled)

Policies with different views of disability coexist; societal values shape policies and persist even if ideas have changed and therefore ideas of 1910 or 1940 coexist with those of 1990 or later

Medical and economic models of disability originated between 1910-1970; and in N.A the individualist mindset resulted in economic model of disability; main concerns were to distribute and reduce the costs associated with limited productivity.

Progress re; health and education, housing and transportation but not re: income and employment;

Canada's welfare state - welfare states evaluated by emphasis on capitalist development vs provision of social entitlements to citizens; Canada is a market-oriented welfare state; not much income security focus;

Current view on disability does not acknowledge that all people with a disability need adequate income support regardless of cause of disability

11/05/2021

Tuesday, May 11, 2021
3:50 PM

Reading A **Review of Disability Policy in Canada McColl et al., Dec, 2017**; financial support from Canadian Disability Policy Alliance and its financial support of the Canadian Disability Participation Project; 1st edition was one of first research activities of CDPA; Canadian Access and Inclusion Project funded by Human Resources and Skills Dev't Canada

Purpose of this report is to provide a comprehensive survey of disability policy in Canada, Provinces and Territories;

"We know what is needed to support effective disability policy in Canada - research is available to provide evidence for good, sound disability policy; what we need now is context specific and policy relevant synthesis of research"

There are 54 federal statutes on disability issues and 410 provincial ones; date from 1973 - 2014 with one from 1954 from the Vancouver charter about disabled parking and non-discrimination by businesses.

Taken from Disability Policy in Canada:
Policies with different views of disability coexist; societal values shape policies and persist even if ideas have changed and therefore ideas of 1910 or 1940 coexist with those of 1990 or later

Language in statutes: accessible, accommodation, affordable, allowance, assistance,barriers, benefits, barrier-free, care, claim, compensation, disadvantage, discrimination, eligible, entitlement, impairment, intervention, needs, persons with disabilities, program, rehabilitation, skills training, services, support, treatment. **All this points to a problem with the individual in need to assistance. Someone who is not "good enough". Normalizes the population who is not "in need" of assistance.**

Purpose of report: lack of progress on federal disability legislation may be due to paucity if sound evidence on which to build disability policy. Difficult questions and ideological tensions. Difficult for policy makers to relate to disability community. Need to have supportive disability policy environment and to understand policy context. As of 2014, a new era appears to be dawning in disability policy. The current government has appointed a Minister with the explicit portfolio of disability issues, and she has made clear her intention to hear from Canadians about what type of legislation would ensure their access to opportunities and inclusion. Consultations are currently underway, and draft legislation is expected. Furthermore, discussions are afoot about Canada's signing the Optional Protocol of the UNCRPD in 2017, representing a commitment to accountability for the articles of the Convention.

Problem is that disability is still individualized, seen as disadvantaged, in need of support and assistance

13/05/2021

Thursday, May 13, 2021
2:44 PM

Reading Canadian Disability Policies in a World of Inequalities Deborah Steinstra, 2018

Disability is a historical structure in the global economy; globalization reinforces relations of dependency for people with disabilities;
Disability in Canada often problem solving vs critical: problem solving is a narrow approach to identify and address "sources of trouble"; critical theory is a historical approach to identify the context within which policies are established and implemented; focus is not on policies or "sources of trouble" but on context within which policies exist; **helps identify power relations and to identify patterns sustaining relations of inequality and seek opportunities and possibilities for change**

Canada is capitalist, market-oriented economy using natural resources and rely on exports; disparities exist due to colonial actions that have led to inequalities; neoliberal policies in late 1990 and early 2000 eroded previous liberal welfare state, leading to unequal income, housing and food security; assumptions and practices were intertwined with settler-colonial practices

There is diversity between disabled people in Canada due to gender, age, impairment, class, race and Indigenousness; Canadian disability policy is shaped by deeply rooted historical threads requiring responses to resulting inequalities

Looking at disability policy from indigenous-settler and human rights lenses; Disability is established as a marker of difference; colonization introduced the medical model of disability to the Indigenous and continues as a standard for claim and care

Convention of Rights for Persons with Disabilities - UN; and Charter; set standard for acceptable treatment and shape education, transportation, housing and commitments to address diversity of the Canadian population; results in tensions and what Canada aspires to be; agreements form normative frameworks; this should influence transformative inclusion;

Disability is constrained by colonial structures; introduced perspective of disability linked to global Northern views of individualism and the medical model of disability with a labelling and "fixing" focus

To address disability means addressing tension between human rights seeking disability recognition and to be valued and the indigenous approach the rejects difference and the results from naming the disabled

Colonial systems and practices have resulted in marking a difference of bodily impairment, a devalued body and a medical model of disability

Considering disability policies alone is inadequate to understand the experiences of exclusion and inclusion related to disability in Canada; material circumstances of the disabled in Canada reflects underlying power relations in disability, gender, Indigenous etc. Human Rights protections but there are competing ideas regarding disability that reinforces neoliberal ableism and human rights do not change the underlying power relations AND human rights reflect colonial assumptions and thus difficult to decolonize inclusion;

Opportunities: requires humility and decolonialization from the settler population and methods valuing both Indigenous and non-Indigenous ways of knowing; mutual learning without privileging Western ideas or appropriating Indigenous ones

21/05/2021

Friday, May 21, 2021
12:45 PM

Reading the Evolution of Work Place Mental Health in Canada

Thoughts: Media attempts to individualize mental illness; MHCC in opening minds has goal to promote environment and context for those with MH issues for help, treatment and support as well as recovery; suggests that this is an individual with a need for assistance to be like everyone else through treatment and support leading to recovery

It is important to examine where ways to deal with WPMH has come from and also to see how the way of looking at a "problem" may lead us to an entirely different end result than anticipated;

Research grants decide what the focus of the research should be for recipients to get funding; this directs what gets highlighted and what is silenced;

Research focused on the individual and MH and thus ignores other contributors; also looks at MH as a particular type of problem

31/05/2021

Monday, May 31, 2021
9:15 AM

Finished reading **The Evolution of Psychological Wellness in the Workplace: A research report**

Areas covered were: **Legal and Standards state:** gaps identified: 1) need best management practices for the improvement of mental health in the workplace 2) need a knowledge exchange centre to share the best practices 3) need best practices re: compensation for occupational stress 4) need the form partnerships and promote workplace wellness practices

Business state: gaps identified: 1) need collaboration of insurers of claims data and impact of mental health in disability claims 2) need standardized measures and large data sets and to study the impact of mental health on work capacity 3) need standardized approaches to assess the business case for workplace mental health 4) need enhanced counselling/EFAP accessibility for workers 5) need additional research on work life balance, flexible work arrangements and organizational culture interventions 6) need enhanced leadership support for workplace mental health 7) need reduced stigma/discrimination and improved accommodation for workers entering and re-entering the workplace after MH absence

Education and Training State: gaps identified 1) need for improvements and adaptation of initiatives providing supports and training in workplace mental health approaches for managers

Media State: gaps identified: 1) need open education initiatives to direct political and public attention toward mental illness and reduce stigma and discrimination 2) need increased public discourse from public figures etc 3) need accurate, non-stigmatizing media coverage of mental illness

Research State: no gaps identified - 1) increasing focus on examining the broader, organizational and work environment factors that impact individual worker mental health 2) increased value on intiatives with research and business collaboration and impact on workplace absence and productivity as well as presenteeism 3) increased research evaluating effectiveness of mental health interventions in technological diverse options moving to work versus other settings **(looking at self-management and peer support - individualized interventions)**

Sector: gaps identified across all sectors as no focus before on workplace mental health; 1) universal framework for PH&S across all sectors 2) viewing worker mental health in relation to job factor conditions and making some sectors therefore being leaders 3) creation of tailored PH&S standards (**if one size does not fit all, why try to create any standards? Is it assumed that all within a particular job category will need the same intervention? Are there other factors outside the workplace that impact worker mental health? This is overlooked by this approach)**

Conclusions: work/life balance, economic security, part time work, technological advancements in the workplace, working from home, blurred line between work and home, high employee turnover, short term contracts, millennial employees - all must be considered when looking at future directions for workplace psychological health and safety

Has the evolution gone from a medical toward a social model (focusing on the workplace); is this to the exclusion of other factors that impact the mental health of people? What is being overlooked?

02/06/2021

Tuesday, June 1, 2021
10:14 AM

Reviewing **Disability Management: Opportunities for Employer Action**
starting chapter 7: The Employee Experience

What is the correlation/causation between workplace absence, MH and medical treatment, medication, Disability Management/absence management?

assumption in article: employees who have taken a LOA due to health reasons can give insights to employers, that may enable them to better support employees

Model of Causes of Workplace Absence: this article believes DM and absence management can decrease workplace absence; BUT what is another factor is MORE indicative of Mental Health issues resulting in LOA?

03/06/2021

Thursday, June 3, 2021
8:32 AM

Reviewing Disability Management: Opportunities for Employer Action

Conclusion: absenteeism is a silent productivity killer. Absenteeism is an issue that affects employer, the economy AND the emplyee (in terms or decreased earnings and quality of life); **MY THOUGHTS: this way of looking at the "problem" is addressing it from a business perspective and seems to be putting this before the wellness of the individual and seems to lose track of the issue of mental health completely**

04/06/2021

Friday, June 4, 2021
2:17 PM

Re-read "**Prostitution and Sex Trafficking: What are the Problems Represented to be? A Discursive Analysis of Law and Policy in Sweden and Victoria, Australia"**

Lay out of paper: Literature review of what is known currently about prostitution and sex trafficking; advises about the method and purpose of the questions; Answers questions one after the other in a few paragraphs; does not separate the articles used to investigate or find solutions to the problems; leaves the last question about proposing her own solution and analyzing this;

10/06/2021

Thursday, June 10, 2021
7:12 PM

Conceptual logics: meanings that must be in place for a particular problem representation to cohere/make sense

1. Medical model of disability brought over by the Europeans - colonialism (Steinstra, 2018)

Canadian context: (Jongbloed, McColl, Steinstra)

Welfare state based on income equality

Group over the individual - collectivism

Respect for authority

Need for state intervention

Capitalist development vs social entitlements

Resulting research of disability policy in Canada (Thorpe & Chenier, Samra) based on the medical model

12/06/2021

Saturday, June 12, 2021
1:38 PM

Reading Contesting Illness: Processes and Practices

Ch 2 Michael J Prince: Claiming a Disability Benefit as Contesting Social Citizenship;

Social insurance plans are pivotal to the development of modern welfare states; citizenship is a contested status; Citizens must subject themselves to procedures and institutions to ensure that the state can continue to provide "rights"

Process of application is a relation of authority where power relations are active

Compulsory contributions, labour force attachment are requirements for social insurance which is an earned right BUT rights are not automatic and the state intervenes in every case

There are 4 modes of power in social programs: overt contestation, service provision, coercion/control and self-compliance

Power relations: authority and inertia of state agencies; prestige and expertise of medical professionals; agency of the individual

Some power relations not contested: service provision and self-compliance which are taken for granted and program goals and administration practices and outcomes are accepted and internalized; IF they were recognized as political, then they could be questioned

Whose interpretation of a person's need is priviiledged? Medical, actuarial, bureaucracy, legal, personal and rehab

Getting a disability pension is disciplinary and political

14/06/2021

Monday, June 14, 2021
7:35 PM

Reading: contesting illness: process and practices

Ch 4 Managing Workplace Depression: Contesting the Contours of Emerging Policy in the Workplace K. Teghtsoonian, 2008

16/06/2021

Wednesday, June 16, 2021
7:09 PM

reading ch4 in contesting illness:

What makes it WPMH? Immediately looking at mental health through a business lens compared to a medical discourse as put in policy, or are these discourses embedded in eachother?

As mentioned in ch 4 p 77: "attempts to breach "enclosed expertise" of biomedical authority by insisting that it be subordinated to managerial expertise more in tune with the imperatives and priorities of the workplace.

19/06/2021

Saturday, June 19, 2021
9:47 AM

Reading In Unison:

Executive Summary:

A NEW APPROACH TO DISABILITY ISSUES

OLD...	**NEW...**
Recipients	Participants
Passive Income Support	Active measures to promote employment in addition to providing necessary income support
Dependence	Independence
Government Responsibility	Shared Responsibility
Labelled as "unemployable"	Identification of work skills
Disincentives to leave income support	Incentives to seek employment and volunteer opportunities
Insufficient employment supports	Opportunities to develop skills and experience
Program-centered approach	Person-centered approach
Insufficient portability of benefits and services	Portable benefits and services
Multiple access requirements	Integrated access requirements

Way of looking at disability still does not question category of disability as an individual issue that must be resolved and the central focus of employment and income

In Unison is a vision made up of values, principles and building blocks that affirms the importance of ensuring the full participation of persons with disabilities in society.
Persons with disabilities participate as full citizens in all aspects of Canadian society. The full participation of persons with disabilities requires the commitment of all segments of society. The realization of the vision will allow persons with disabilities to maximize their independence and enhance their well-being through access to required supports and the elimination of barriers that prevent their full participation.

Portrays persons with disabilities in need of disability supports, employment and income in order to be able to participate as full citizens…as outlined above;

The Canadian approach does not promote special treatment for persons with disabilities but recognize the need for specialized services for persons with disabilities within the generic framework for service delivery; **the goal is to offer the same opportunities meaning that the "problem" of disability is viewed as the lack of opportunities**

20/06/2021

Sunday, June 20, 2021
1:56 PM

Finished reading In Unison:

Puts people with disabilities at the centre and subject position without questioning this category not the fact that different providers and agencies have different eligibility criteria to create this category

Report is a blueprint for promoting the integration of persons with disabilities in Canada; **difficult to integrate "persons with disabilities" as this is a fluid category depending on context**

Building blocks of program disability supports, employment and income; therefore the problem of disability is the lack of these; Regarding income: this does not suggest looking at results but on efforts suggesting that the disabled cannot be judged as other commensurately employed (does this make them lesser?) and possibly that they may not even be able to do that; is the lens through which we value the disabled reflective of a capitalist, neoliberal lens?

Categories:
A Canadian Approach: not promote special tx of disabled BUT need for specialized services within generic framework
Values: Equality, Social Union, Federalism
Principles principle of inclusion; increase full participation of persons with disabilities
Inclusion: rights and responsibilities; empowerment; participation
Full Citizenship: inclusion of people with disabilities in all aspects of Cdn society
Building Blocks: Disability supports, Employment, Income

Disability Supports: portability, individualized, affordable, depending on peoples needs
Employment: accommodation, assist for disabil-related cost, improve comm econ dev't, access to education
Income: decr disincentives to work, separate access to dis supp from eligib for financial assist, coord assessments and rehab, financial assist when work interrupted
Accountability Framework; annual reports EAPD
Next Steps: vision: full particip for ppl with disabil

There is a focus on the "doing" person versus the "being" person; inherent value of the individual is missing; society of doing; lens through which ppl with disabilities are looked at is a doing lens;

26/06/2021

Monday, June 21, 2021
7:27 PM

Finished reading **Canada's universal health-care system: achieving its potential:**

Conclusions: When Tommy Douglas first established public health insurance in Saskatchewan in the late 1940s, his goal was to begin by creating insurance models that would **eliminate the financial barriers to care. (did not question that medical care was the solution, but advocated that medical care needed to be provided to all Canadians)**

second reform of health service delivery that would focus on **population health needs**, with an emphasis on the **reform of delivery models** and on the **social determinants of health**

To achieve that second stage in the 21st century, determined action on the social determinants of health and a joint effort by governments, health-care providers, and the public in achieving health system reform will be needed

Decentralization of delivery: defining feature of medicare

Doctors are most commonly independent contractors, billing public insurance plans on a fee-for-service or other basis.26 Despite the fact that they work within the boundaries of regional or provincial health authorities and in hospitals financed almost entirely publicly, few accountability relationships exist between physicians and health authorities, hospitals, or governments.

Role of physicians:
By contrast, Canadian physicians remain primarily self employed, independent professionals. Ongoing conflicts are fuelled by mounting pressure to alter this arrangement and **increase professional accountability** for and to the system.

As **founders of evidence-based medicine** and important contributors to global medical research, Canadian physicians must help to lead the necessary research and debates on change within the health-care system.117 They are critical partners in ensuring quality, consistency, and availability of services.

Prescription meds: expanded public coverage of prescription medications will necessitate a drive towards more evidence-informed and Series www.thelancet.com Vol 391 April 28, 2018 1731 value-based prescribing

My thoughts: If we are looking at the "problem" being universal access to medical treatment then the solution is to involve gov't and physicians to expand these services to more people as well as to increase the number of services available;

(only) 70.9% of total health expenditure is publicly sourced; lower than most other countries in Western Europe;
Saskatoon Agreement, a truce whereby doctors would become part of the system as publicly paid but self-employed professionals with minimal engagement in or accountability to system-wide governance.

Social Determinants of Health: The Lalonde Report of 1974 (panel 3) served as a catalyst for widespread recognition that health is determined more by social, cultural, economic, and gender-based determinants of health than by access to health-care services.41 In a country where the contribution of health services to health is estimated to be only 25%, the impact of other determinants including poverty is considerable.
Thus, as is the case across high-income countries, policies aimed at income redistribution, housing support, and early education and childhood development programmes will continue to be crucial to the health of the population

Policy challenges: The high degree of physician autonomy in Canada does little to encourage doctors to join organised programmes to reduce wait times. However, physicians have competing responsibilities, and there is no systemic support for their involvement in system change. If a government or regional health authority wants physicians to participate in such an initiative, it must often rely on exhortation or simply pay its doctors more to gain their involvement.

BUT: Canada's reasonable performance on composite quality metrics such as amenable mortality suggests that these **wait times for elective care do not necessarily translate to worse health outcomes**. However, for the **Canadian public, long wait times for elective care are a lightning rod issue and threaten to undermine support for Medicare.** My thoughts: so are long wait times really a problem if it does not change health outcomes??? **Seems more a function of public perception that they need medical care!!!**

Indigenous health disparities: Other far-reaching inequities exist in the social determinants of health that even the best health-care systems cannot redress. Indigenous Canadians face substantial wage gaps of up to 50% compared with nonIndigenous groups, after adjustment for education and age.99 Persistent racism and social exclusion permeate not only the health-care but also the education and justice systems, with subsequent disparities in high school education rates, incarceration rates, and other factors often driving egregious health statistics. My thoughts: **Therefore, does increasing access to medical care truly help this population???**

24/07/2021

Saturday, July 24, 2021
10:43 AM

Answering Question 4: **What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be thought about differently?**

03/07/2021

Saturday, July 3, 2021
9:40 AM

Read wikipedia **Sweden and the UN**

Sweden's disability policy

Categorized under;

Education
Housing
Transpotation
Finding a job
Justice System
Digital Strategy
Legal Right to Independence
The Discrimination Act, 2009
International Cooperation

Sweden provides legal protection to persons with disabilities; while this is ahead of Canada providing such protection, the category of "persons with disabilities" may still be a nebulous concept and poorly defined with blurred boundaries. Is the legally binding policy further stigmatizing those with disabilities?

Seems that the **Standard Rules on the Equalization of Opportunities for Persons with Disabilities** is using the Critical Realism paradigm where persons with disabilities are viewed as a "thing" to be manipulated…

Difficult to make 22 Rules for an undefined entity like Disability; due to nature of this lack of clarity on disability, it is difficult to make rules that are specific and even applicable

05/07/2021

Monday, July 5, 2021
7:50 PM

UN Convention on the Rights of Persons with Disabilities, Sweden ratified in 2008

Obervations after reading preamble: too vague; not specific and measurable to make doable;

People with disabilities is the central concept and focus of this entire document; if this concept is not defined and not specific the whole document falls apart (glass brick in building a brick wall)

10/07/2021

Saturday, July 10, 2021
2:17 PM

Central focus point is persons with disabilities; it is considered an entity around which the Articles or regulations are made; in stating that everyone is entitle to rights and freedoms without distinction - but does not naming ppl with disabilities automatically distinguish them simply by calling attention to them?

Multiple non-specific words such as persons with disabilities, full enjoyment, without discrimination, conditions of peace and security, full and equal enjoyment, dignity, reasonable accommodation, appropriate, effective, undue influence, tailored to person, these are all open to judgement and interpretation and therefore difficult to enforce; lawyers would have a field day with this;

Stating that the majority of ppl with disabilities live in poverty, does disability beget poverty or does poverty beget disability; should the focus be on poverty versus on disabiliy?

"best interests of child" Article 7; in whose opinion is this determined?

Article 8: to recognize the skills, merits and abilities of ppl with disabilities in the context of the workplace and labour market. Why?? Are ppl with disabilities only as a particular kind of person in relation to the workplace and not consider other attributes?

Article 12: all measures rel to exercise of legal capacity should be appropriate and effective; in whose opinion??

Article 25: States should ensure access for persons with disabilities to gender sensitive health services and health related rehab; this perpetuates idea that ppl with disabilities are **in need of (health) services**

11/07/2021

Sunday, July 11, 2021
10:18 AM

Scandinavian disability policy: From deinstitutionalisation to non-discrimination and beyond

Moving from welfare policy to social regulation; but many loop holes where legislation does not exist and ppl falling between cracks;

Two areas; institutionalization and accessibility;

14/07/2021

Wednesday, July 14, 2021
7:03 PM

Purpose of LAS to keep people with reduced ability in work;

Zero Project was initiated by Essl foundation in 2008; with mission to support CRPD of the UN; it partnerships with the UN, international membership organizations, internaional fund agencies, academic instituations, NGO, DPO, professionls, activists: this lens if viewing people with disbilities is wide and through networks. Perpetuates this view - Critical Realism, - repetition of practices - not easy to undo!!!

17/07/2021

Saturday, July 17, 2021
10:23 AM

Sweden does not view disability differently than Canada. This is determined by the UN and holds a Critical Realist lens on the category of "people with disabilities". However, how this category is dealt with differs between the two countries in that the goal of Sweden is to protect employees with disability related decreased ability to work in general labour law has helped Sweden create the most inclusive labour market of the whole OECD.

The above is from the worker lens: Bill Wilkerson combined the employer responsibility with mental illness and therefore this it the lens through which Canada looks at ppl with disabilities. But also 100% or 0%. No in-between. So while Sweden has the same lens in terms of looking at ppl with disabilities as a "category" which therefore cannot be changed, their business practices around this group differs from that of Canada's with respect to workplace practices.

The other way Sweden and Canada differ, while still keeping the category of ppl with disabilities, is that those who are not in the active workforce have support from the Federal Gov't above minimum subsistence (McEachern)

Impact transfer program: since 2018 20 projects are selected that have a proven impact model and potential to scale their impact internationally, i.e project is an innovation that can be transferred to other regions, countries or adapted for other disabilities. And org must have replication as part of strategy.

Reading The Swedish Mental Health System: Past, Present and Future, 2000
Swedish Health Care Act, 1982 - this seems to have been a big year globally, and also reflected in the changes in the LTD policies in 1982 also

18/07/2017

Sunday, July 18, 2021
10:03 AM

Continuing with **The Swedish mental health system: Past, Present and Future**

Psychiatric Care reform in 1995;

Category of people with mental illness is a category seen to be in need to tx and support; consequently, there is a push to get these services;

State that the roles and responsibilities of the state etc are unclear; but if the caterogory of people with mental illness is not clear to begin with, then how can services be clear?

Indicated that collaboration and coordination of services is needed, but if the shared vision is looking in the wrong direction, how will this help?

20/07/2021

Tuesday, July 20, 2021
7:41 PM

Strengthening prevention and treatment in mental health; article in Science and Business from April, 2020 highlights why Sweden is a place to consider when looking at the shortage of evidence-based treatment for people with mental health issues as it otherwise is a

Due to the complexity of mental health diagnosis and data collection, around half of all people with mental health problems **do not receive evidence-based treatments**. And this treatment gap is a **major threat to health system sustainability**, with direct and indirect medical costs of more than €600 billion per year in the EU. Defining the problem as lack of evidence based treament

21/07/2021

Wednesday, July 21, 2021
7:39 PM

How to Strengthen Prevention and Treatment in Mental Health;

Keep mental health on the political agenda

1. Costs to eer's huge
2. Policy holders should act, but no expect quick fixes
3. Cross agency coordination and cooperation needed

Help Young People Pursue Mental Health

1. Educate kids early
2. Decrease inequality in mental health care for kids

Figure out which investments are paying off

1. Analyze interventions that work and those that don't
2. Focus on outcomes and actions

Make better use of Public Data

1. Link national registers on **Life spans, quality of life, psychiatric disorders to improve treatment.**
2. Support **integrated learning, new research** and **improve the management of programs**

The Value of Early Interventions

1. Increase the ease to get help before problems get bigger

2. Decrease the stigma of mental illness

Employers need to be flexible

1. Need mental health education throughout life
2. Access to free counselling
3. Decrease the consequence to employees seeking mental health treatment
4. Help people with mental health issues work part time

Harnessing New Tech can help

1. New technology can help deal with problems while small
2. Virtual Reality can help treat phobias
3. Low voltage electricity helps with depression

Both tech know-how and trust are required

1. Teach patients and kids to use digital tools
2. Introduce certification for mobile app's and digital solutions

22/07/2021

Thursday, July 22, 2021
6:37 PM

Articles:

1. Sweden member of UN since 1946
2. Full participation in sociatey is top goal of Sweden's disability policy
3. Standard rules; **The purpose of the Rules is to ensure that girls, boys, women and men with disabilities, as members of their societies, may exercise the same rights and obligations as others.**
4. **Purpose:** The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
5. **Deinstitutionalization and social regulation**
6. **lesser capability because of age, illness or acquired disability is not an objective ground for dismissal and employers must make all reasonable efforts to retain the worker.**
7. **The resulting division of roles and responsibilities creates a strong need for collaboration and coordination of activities on behalf of consumers. It can also have the unintended disincentives to serving more difficult consumers.**
8. And this treatment gap is a major threat to health system sustainability, with direct and indirect medical costs of more than €600 billion per year in the EU.

So who has the answers to solve this conundrum? Sweden is without question one of the best places to look. The government introduced a new national mental health strategy for 2016-2020, which focused on bridging the gap through prevention and awareness, accessibility to care and greater emphasis on vulnerable groups.

Round able to look at how governments, education systems, and new technologies can help treat and prevent mental health problems. Focuses on innovation in health care systems

Sweden still looks at mental health as an issue in need of help, treatment etc.

26/07/2021

Monday, July 26, 2021
7:51 PM

Ques #5: **What effects are produced b y this representation of the problem?**
To identify the effects of specific problem representations so that they can be critically assessed.
Consider three kinds of effects: **discursive effects**; **subjectification effects**; **lived effect**s. Include effects due to **dividing practices**. The following sub-questions will assist here: **What is likely to change with this representation of the 'problem'? What is likely to stay the same? Who is likely to benefit from this representation of the 'problem'?** Who is likely to be harmed? **How does this attribution of responsibility for the 'problem' affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?**

Goal of this question is to identify the effects of specific problem representations so that they can be critically assessed.

Reading first Stuart et al, 2014: **Opening Mins in Canada: Background and Rationale**

There were 103 youth programs and 130 h.c.p programs volunteering; 20 youth chosen and 17 h.c.p; categories will impact results; man programs were not proven effective or evaluated; evaluation by researchers introduced another lens;

28/07/2021

Wednesday, July 28, 2021
7:04 PM

Reading: **Opening Minds in Canada: Targeting Change**

Interesting how researchers have worked their way into community stigma initiatives…this is how they influence them; make sure that the programs are viewed from a particular lens…

Address target groups; youth, health care providers, workplaces and media; standardize measurement across programs - made them pre-determined and only possible to give some answers;
Placing people in categories and then determining how intervention should be; is this individualizing or trying to save money placing people in artificial categories (just like mental illness is a stigma) are youth, media, workplaced and hcp also stigmatized by this approach?

Does the UN, through its rules and articles perpetuate ppl with mental illness as needing help and thereby creating more stigma?
Who among people believe in true equity where some are given more to be the same as others? Is that necessary? Are people then valued for their differences? Is money the ruler against which equality is measured?

31/07/2021

Saturday, July 31, 2021
3:18 PM

Reading **Mental Illness and employment discrimination - (Stuart, 2006)**

What effects are produced by this representation of the problem?

Stigma.

Purpose of review: Work is major determinant of mental health + socially integrating force; Exclusion results in material deprivation (lived effects) decreased self-confidence, increased isolation and marginalization, increased risk for mental disability

Summary: multiple attitudinal and structural barriers prevent people with mental disabilities from active participation in the competitive labour market

Looks at stigma as a "thing" along with people with mental illness

Employment has a "normalizing" effect providing structure and routine, goals, increased self-esteem and self-image, increased finances, decreased poverty, increased friendships and social support, increased quality of life and **decreased disability ????**

Historically, competitive employment has not focused on mental health symptoms; there have been minimal expectations and decreased standards of achievement for people mental illness; **Modern Mental Health treatment philosophy based on the premise that people with mental illness have a right to live and work in the community and therefore people with mental illness need access to community based treatment and rehab services, safe and affordable housing and equal access to employment opportunities commensurate with their skills, interest and training. - solution is tx, rehab etc. problem is lack of this**

Stigma and Employment eqity: unemployment rates are high for people with serious mental disorders; varies by diagnosis and people with mental illness are largely recipients of social welfare; is this because the **job demands and the goal of keeping the status quo and getting the job done - keeping people with mental illness on welfare? Or is the goal to keep those with mental illness working?**

Benefit trap: to work may mean jeopardising disability benefits; people with mental illness less likely to be in competitive employment or earn less - possibly due to less education or training; therefore to increase training for people with mental illness; **Viewing the problem in this way limits the actions that can be taken and perpetuates the belief that it is something about people with mental illness themselves who are lacking**

Stigma results in less use of EAP, tx etc and few managers know how to deal with mental illness BUY: those who seek tx for depression show increased work performance and less sick days which offsets employer costs. **Therefore, to decrease stigma, organizations need to identify and manage mental health problems of workers and support mental health and psychosocial recovery => by addressing**

the problem as a lack of treatment that is responsible for decreased work performance and increased sick days we perpetuate the problem of the individual with mental illness

Benefits of disclosure: protection under anti-discrimination legislation BUT if no cases have been successful for those with mental illness in the US, what protection is this?

04/08/2021

Wednesday, August 4, 2021
8:16 PM

Reading Public Stigma and Self-Stigma: Differential Association with Attitudes Toward Formal and Informal Help Seeking

Individuals needing psychiatric tx avoid help-seeking due to stigma; need for psychiatric treatment' discursive effects; not possible to thing that solution is not medical care;

Respondents awareness of other peoples' stereotyoes about service users deterred them from acknowledging the importance of informal care.

07/08/2021

Saturday, August 7, 2021
4:41 PM

Summary thoughts about article 5(5);

What's happening by **focusing on stigma** (preventing help seeking) take people with mental disability in need for medical treatment as a given that is not questioned; Not possible to question the need for treatment (medical model) and focus is instead on WHY these people don't accept the commonly supported notion of people with mental disabilities in need of treatment

Article claims that issues of cost and access to treatment are issues, stigma is a main factor preventing treatment seeking; they go on to say that **campaigns are effective BUT** there are wide variations and that perhaps the targeted messages and audiences are not as specific as they should be…in that case, **how effective are they??**

"stigma is multi-dimensional and targeting the treatment-seeking process could increase the effectiveness of mental health campaigns IF the goal is to view people with mental health conditions as needing medical treatment" Is this a way to perpetuate the medical view of mental disability?

Need to target the help-seeking process: not perceiving the need for treatment is the most commonly cited reason for not seeking treatment among individuals with mental illness; fear of stigma, embarrassment, negative attitudes to treatment - may contribute to perceptions of not needing treatment **or is truly treatment the best solution for people with mental illness (by focusing on stigma, this way of viewing the "problem" is not questioned)**

Negative beliefs about treatment and mental illness, as well as the intent to conceal a mental illness are significant predictors of perceived need for treatment (**no shit shirlock**)

For those with unrecognized need (of treatment), need to address personal beliefs about Mental Illness (so is no dissenting view acccepted)?

Worldwide efforts to decrease stigma of mental illness and to increase treatment seeking, **requires people with mental illness to be seen as in need of something**

Programs targeting those not recognizing mental illness and the need for treatment => need to address personally held stigmatizing beliefs T**HEREFORE if not in agreement with an individual problem and something wrong with the individual these people's personal views need to be changed.**

Those acknowledging needs of treatment should focus on increasing mental illness knowledge and **THEREFORE people already in agreement need to learn MORE about this way of viewing the problem**

18/08/2021

Saturday, August 14, 2021
1:20 PM

Reading 6 (2) In Defence of Madness: The Problem of Disability

Challenging view that madness is inherently disabling and cannot form ground for identity and culture

Intro:

concern is A) **disability, limitations/impairments of daily function and participation**
not distress: affective states fear, anxiety, sadness

B. Not arguing against medical model of disability but to assume it too readily in M. I.

Positive framing of something inherently negative? How is that possible?
It is absurd to urge people to embrace and respond positively about MI and of something to be proud
MI being inherently negative will always cause suffering
Disability is not distress BUT not arguing against medical model of disability but to assume too readily in the case of madness

II: clarifying the critcism:
Mental illness associated with disability - but association is not contingent; limitations experienced by individuals with the condition is due to the condition, not the fact that it is intolerated or unaccommodated by society

Criticism: in a utopian world with no discriminination with well-meaning people, mental illness is still decreasing the well-being of those afflicted;

Response to criticism: mental illness is a variation on human experience and ways of being; reasons variations lead to problems in function is due to the social world that is not set up to accommodate them

Most MI is seen as disorders because they prevent the person from functioning properly in a social world we set up; If the majority of the population was bi-polar we would set up things to accommodate them and those without bi-polar disorder would struggle to fit in
majority rules: neoliberal???

III: Models of Disability:
Priority given to impairment or social context; medical or social model;

Medical: variations as primary cause of limitation - prescribe medical corrections and/or financial compensation
Social model: limits arise from the physical and social environment designed/conducted that excludes or does not take into account individual variation

Basic actions vs complex/generated action; 2 types of limitations basic inabilities and disruptions to complex activity;
Iimpairment is limitation at the basic level and not sufficient to say there is a limitation at the level of complex activity. Complex actions are always performed in the physical or social environment and our ability to realize our goals depends on the **match between the environment and our abilities;** extent on which disadvantages are conditional on social conext

2 levels of limitation: basic inabilities vs. disruptions of complex activity; match between our the environment and our abiliities

CDI: conditional disadvantage of impairments - Disadvantages experienced by people with impairments but are produced by the social context in which they live

UDI: unconditional disaadvantages of impairments: disadvantages experienced by people with impairments and are produced irrespective of social context

BUT: the notion of an absolutely unconditional disadvantage does not work; the basic inability is made salient in the context of failing to achieve complex action and the latter is itself related to the physical and social environment; the **distinction is in degree not kind**

Distinction between UDI and CDI is to limit oversocialization of **Radical form of social model of disability denies a role for impairment generating disability**

There is no hard line between CDI and UDI; the distinction is worked out in practices leaning heavily on disabled peoples' experiences and the demand for social accommodation

IV: **Naturalism, Normativism and Disability**

- critics of the medical model of disability, claim that limitations caused by an impairment pre supposes a naturalistic view of function

Naturalism - view that norms of physical and mental function can be objectively determined; the normal function of a part or process is statistically typical contributed by it to the individual **survival and reproduction; normal function** is determined by the reference class; this is value free in terms of deviation from natural function; **BUT evaluative component in light of personal, social and medical norms and values; defining dysfunction is not value-free; functional limits are judged by persona and social values and norms (DCM training by SLF on how to interpret and apply policy)**

Problem with naturalistic theories is that defining dysfunction in value-free terms is not successful; continuous curve deviance from mean becomes suboptimal function; functional limitations are judged by personal and social values and norms;

Dysfunction is normative, not a natural limit;without considering this point would not examine these norms etc to see if can be modified to reflect positively on persons ability to function and thrive through society; goes against individualization of difficuties others face andtendency to medicalize vs coming to terms with social solutions (what activists are asking for)

Judgement of whether to intervene as the individual or social level can't be determined through and account of natural function and dysfunction but through pragmatic and ethical factors including considerations of efficiency, safety and equality

V: Applying the Social Model to Madness

Concern with long-lasting conditions, substantial effect on daily activity and tx not desired or possible

The disability movement must be cohesive in their approach (against the medicalizing individualistic approach); problems: **A) reluctance of Mad movement to accept the social model** of disability and to adopt terminology interpreted by physical disability activists as disablism: refusing to be referred to as disabled and asserting no tangible real impairment; contributes to idea that disability s fixed + not outcome of interaction b/w individual capacity and the physical/social context **B) fear of increased stigma** blocks a shared discourse and activities between disabled and Mad movement (double stigma)

Need framework: account of interaction between individuals and society related to production of limitations

Relevant mental variation: made salient with disruption of complex activity (i.e work); Rethink Mental Illness - stigma and negative attitudes of colleagues can undermine adjustments otherwise effective

Stigma: is a major issue: without significant change, how people think about madness or MI any adjustment is superficial and ineffective; What lies at the root of problems in society? When unintelligibility comes move from position of accommodation to seeing person as the cause of their struggles

VI: Intelligibility and the Limits of Social Accommodation

Variation differs for (MI) significantly when compared to mobility and sensory variations; at the heart of the social reaction to MH problems is attributed to loss or lack of reason; mobility/sensory variation

(physical) that capacity is not at stake. Assumed lack of reason underpins disadvantage and discrimination of social response to madness; underpins fear, distrust and paternalistic limits of autonomy

Unreason used broadly with range of not being able to meet social obligations (anxiety/depression) to failures in intelligibility in the individual whose behaviour is guided by voices…

Intelligibility is helpful determining the limits of social accommodation of difference; point where we cease considering discourses of social adjustment in favour of those that describe failure in the individual; intelligibility depends on acceptance of assuption of narratives; Challenge is to expand limits of social accommodation of difference and conceive social adjustments; madness asks us to question the total world view our beliefs, values, sense of self, rationality and personhood;

For some, the limits of intelligibility is earlier (slight eccentricity); **limits of intelligibility different for different people** and is when we consider the limit experienced by individuals to flow from the variation itself leading to decreased change in social behaviour versus changing the individual

However: we need to 1) specify the values and standards driving variation as intrinsically disabling thereby possible to change the standard to permit a broader accommodation of difference 2) political activism for demand for social justice

VII: Political Activism and the Social Suspect

Mad Pride activists often makes analogy to Gay and Black rights; but their demands are beyond equalization of civil rights irrestpective of difference; but to recognize difference as a matter of social justice; distinctness of identity in question - claim to respect and equality; demand that society changes to accommodate a broader range of variations in terms of social justice means that the person is a social subject - a human being seeing self and others engaged in a shared project where well-being and equality matters BUT the central aspect of madness is dis-sociality of the subject; ** sign of mad subjects madness if withdrawal from society; difficult to make demand for social justice if MI person cannot be social subject;

How to make demand for social justice? 1) Mad pride activists are not mad 2) scope that some are at the far end of the spectrum and not representative of all but to demand for broader range of accommodation for broad range of variation

View on social justice and understanding of society: limits of intelligibility - by making this demand person is seen as candidate for social accommodation of difference vs medical correction of behaviour - not individual approach; Political demand shows person sociality

Phenomenological psychopath crisis in intersubjectivity; subjects yet to see themselves as social subjects;

Conscious raising of activist literature: people get together, see similarities and interpret predicaments from discriminating social conditions vs individual pathology thereby demand to change conditions; **need to create collective reasonableness and allows viewing as disorders and individual pathology**

VIII: Conclusion

Gay rights, transgender but Mad individuals not yet featured in cones of respect and dignity; still dominated by medical idioms and notions of distress/disability

Disability Model:

1. Normative basis for disability judgements; if intrisically disabling, need to add judgement of values, norms and contexts; As opposed to accommodation of difference as problem with difference itself changes the perspective; we see normative limits constituted by values, norms and abilities that seem natural; therefore can decrease medicalization difficulties and see social solutions
2. Political Activism: to demand social justice -> society to change to accommodate a broad range of variation in function => the social subject is a candidate for accommodation of difference versus individual correction of behaviour

Effecting change in perspective is challenging - social model thinking to mental variations raises issues with variations in physical function (where the social model of disability initially developed)

Madness - challenge to intelligibility - must question broader beliefs and values regarding fundamental notions of self and worldview BUT not insurmountabele; radical challenge to norms and concepts of who we are; Either a moral obligation to change norms and concepts to accommodate broader range of experiences and behaviours?

21/08/2021

Saturday, August 21, 2021
12:52 PM

Reading "Mad" Mad studies and advancing inclusive resistance

Mental distress framed biomedically as mental illness/disorders in professional and political debates and discussed among service users; need to challenge biomedical discourse in policy and thoughts; even "mental health" and "mental health problems" are within the mental health paradigm;

Mad Studies is activism and intellectual activity with origins in Canada; has now moved internationally; it is "a field of scholarship, theory and activism about lived experiences history, cultures and politics about people identified as Mad, Mentally Ill, psychiatric survivors, consumers, service users, patients, neurodiverse and disabled"

Survivors felt biomedical model dominate public and professional thinking => stigmatizing and unhelpful; rec need social support to understand distress and broader social causes **(if we focus on social causes of distress, then logically we need to change the social)**

Users divided about mad and madness; positive, negative thoughts and reservations; **(why is one categorical term needed? This goes against individuality and difference and implies homogeneity); need to find new terminology and there is a failure of the movement to unite around a counter-philosophy**

Distinction b/w survivors and disabled ppl movement; **Disabled ppl movement**: reject medicalizing individuals with disabilities for the social model of disability and philosophy of independent living; Survivors movement: key principles of acting for selves, tx with equality, highlight social relationship of distress;

Mad Studies survivor-led and trying to develop strong philosophy and theoretical base: Mad used as concept with international currency and historically used to describe behaviour that 19th century called mental disorder; Mad frightening word but need to dissociate from biomedical model and reject medical terminology; currently don't have language for extremities of experience and emotions; we may change words but mean the same; Need to increase social understanding and appreciation how madness can result from society and circumstances

Mad Studies field of study linked with activism and based on Western psychiatric system; need to move this to the Southern Hemisphere with consideration for indigenous responses and arrangements and it is seeking to work on this; the movement needs to open itself for more inclusive and wider development

Agenda for Action:

- Early stages of new movement; build diversity and understanding within the movement vs being immobilized by newness
- Explain what "Mad" means
- Making harmless vs oppressive language
- Building alliances with related causes
- Reach out to survivors facing additional barriers and discrimination to support empowerment to ensure an equal role in the movement
- Support development of diverse non-medical individual and collective survivor narratives vs psychiatrically based
- Develop equal links between southern and northern hemisphere building on existing movements
- Focus on survivor organizations versus "for" service charities
- **Spread the word in ordinary ways and places and explain alternatives to psychiatric system and thinking; does not have to be individual pathology**
- **Build and develop social model of experience**

Mad Studies must do this globally; dealing with inferior credibility and discrimination in the distribution of power; need legitimacy and resources; must overcome this (standard) fate of new movements

22/08/2021

Sunday, August 22, 2021
10:56 AM

Reading: Supporting the sustainability of Mad Studies and preventing its co-option

Mad Studies is growing; project of inquiry, knowledge production and political action addressing psy-centred ways of thinking, behaving, relating and being; it is a progressive dev't emerging in m-h policy, practice, discourse to **challenge long-standing psychiatric dominance, stigma and stereotyping. BUT is challenge the best way vs aligning with slight variation?**

Recovery - critiqued for reinforcing neoliberal and market-driven approaches to stress; (initially to decreased stigma and respond to untreatability) used by policy makers to force people to RTW and decrease financial support

Peer support - critiqued for reinforcing neoliberal and market-driven approaches has resulted in decreased access to professional help (assuming that this is needed) and creates low and non-paid ancillaries and assimiate

M.h sx and policies modify ideas and M.S also challenged with the **academic context**: detachment from real life issues and individual competitiveness; therefore intent can do opposite of what intended; can M.S be protected?

Learning from Disability Studies:

Social Model of Disability; Oliver; attacked, revised and reformed; disabled peoples movement was unified with common barriers but now divided and under attack; **(a theory or model is also a discourse or lens);** Ppl talking down model but not replacing: heavy burden of responsibility; ppl must stop talking

Preventing same fate for Mad Studies:

Toward a strategic approach:
Components:

- **M.S need to challenge the divide** between activism and theory building; ideas and practice; some academics critique the model and many people with disabilities are barely aware of it: **Knowledge Transfer**
- **M.S must root itself in user/survivor and disabled people**s' organizations; difficult due to decreased funding and vulnerability of organizationa BUT not help to align with the service system (individualizing) or academy (academicize); needs grassroots collective and rearch organizations and to support the development of user/survivor and disabled peoples' organizations
- **M.S must address diversity and priviledge**: race, class, culture, gender, age, disability, faith and belief; BUT can't be everything to everyone; risks watering down message; what does it stand for? Jack of all trades master of none; Foucault: no 1 solution fits all
- **M.S how** s why and what; participation, inclusivity, non-hierarchichal and non-medicaliation goals need to be embodied in ways to promote: need to share knowledge and learning; need to move beyond institutions of services and academy and using dialogical methods and model of conscientisation (Paul Friere, 1972)
- M.S must direct analysis to topics beyhond **psychiatry** and **mental health** and consider **other relevant scholarship**
- For M.S to get critical mass and impact mainstream needs to **strengthen alliances b/w different groups of service users, professions, disciplines; what about UN?**

23 and 24 Aug, 2018

Tuesday, August 24, 2021
5:15 PM

Reading **Critical Disability Studies with Rehabilitation: Rethinking the human in rehabilitation and practice**

Aug 26: approach to inquiry-post structuralism and critical disability studies critiqquing WHO's ICF; Highlight how social, cultural and institutional mechanis produce and regulate notions of ab/normality and disability identities; question the ontological certainty of the neoliberal human; challenge normative and ableist assumptions

DS scholars find rehab being oppressive due to therapies focusing on **normalizing bodies**

Potential for meaningful relation between CDS and RS; need to re-imagine philosophical and political differences between CDS and rehab

CDS - not just a conceptual lens to critique rehab
Rehab - not just medical practice to normalize impaired bodies

CDS with RS => deeper analysis of plethora of ideas, assumptions, discourses supporting ontology or nature of the ideal and normal abled body; aims to lessen (unintended) harmful effects of traditional (medically based) rehab practices, contribute to the development of critical and transdisciplinary rehab scholarship

ICF Background and Development:

1. Biomedical discourse (medical model); malfunctioning body part; individual biological problem to be fixed
2. Social Theories of Disablement (social model); disability is socially produced by exclusionary practices and unequal access to resources **(medical???)**

Expand medical view of disability

Social Model of Disability not meant to replace but work with and address sociopolitical limitations in solely individual pathological approach; social models often looks at material aspects of impairment; defend the idea that impairments cause disability and are the basis on which disability as social exclusion operates

The medical model and social models are criticized for failing to acknowledge the multifasceted nature of disability and impairment

Medical model shame and blame on the individual and fails to hold society accountable for unjust practices

Social Model dismisses the lived experience of disability and fails to theorize the interrelation b/w disability and impairment: **BOTH cases fail to theorize the relation between disability and impairment**

Dialectical relation b/w biomedical and sociopolitical determinants of health;

WHO: (ICF) for describing and organizing information on functioning and disability that provides a standard language and conceptual basis for the definition and measurement of health and disability

1980 International Classification of Impairment and Handicap: critiqued for adapting the medical model (bioreductionist) view of impairment; biological abnormality;

ICF and rehabilitation

Introduced ICF to change rehab philosophy, practice, education and research; some used as framework for clinical decision making; common language for clinicians; constructed that disability is inherently negative; Rehab therapy drawing on this are limited in ability to help disabled people; calls for new interdisciplinary focus to disrupt taken for granted assumptions re: nature of humans

A CDS critique of ICF:

Implications of ICF for disabled people; underdevelopment of ICF holds potential to reaffirm a reductive understanding of disability and impairment
ICF use of statistical norms to define dysfunction with reductive understanding of impairment
Model pays insufficient attention to the broader social, political, legal, or economical impacts of the production of widespread impairment

Therefore the ICF perpetuates notions of normal and abnormal and reinforces the belief that disabled bodies are inherently problematic and in need of intervention

The Conceptual Model of ICF:

- Production and maintenance of ableism
- Ableism: network of beliefs, processes and practices that produces a particular kind of self and body (corporeal standard) that is projected as a perfect, species-typical and therefore essential and fully human; Disability then is cast as a decreased state of being human
- Move gaze away from disability brings a subtle exploration of theoretical and philosophical assumptions; perpetuate ableist thinking;
- Disability and function is due to the interaction between health condition and contextual factors: environment,personal

BUT, ICF is value neutral: perspective of impairment as objectively defective "problems in a body function or structure - significant deviation or loss; maintains normal/abnormal, natural/unnatural, abled/disabled binaries

Dichotomist thinking privileges some ontologies over others and deviations are in need of fixing; materialist ontology of ICF

Impairment as Inferiority:

Notion of biological (able) body produces impairments as inherently and naturally inferior
Indirectly blames impairments themselves as primary source of harm experienced by people having them; disability is a negative way of requiring intervention

ICF draws on scientific discourses and stats to define what counts as an abled (biological) body

Impairment is a loss or deviation from certain generally accepted population standards

Abnormality is used to refer to a significant variation from established statistical norms; abnormality is a statistical variation presented as an objective fact;

A Post Structural Perspective on the ICF:

Reductive focus of ICF on pre-formed biological materiality materialized through discourse; knowledge and understanding are always mediated by dominant ways of thinking;

Abnormal body is only real in that it is produced by discourse and therefore: impairment is not some natural (deviant) state but constitutes a mode of living that changes over time due to the way it is shaped and re-shaped by discourses and particular ways of knowing

ICF fails to address how discourses mediate understanding; despite the intent of the ICF (a value neutral classification) does not challenge ideas that exclude, separate and subordinate people with disabilities and institutions and actively promotes separation

ICF relies on a biomedical notion of impairment as objective and defective AND based on statistical norms to understand what counts as a problem to be addressed

ICF may acknowledge: 1) social mediators of disability IT 2) reliance on discourse on normal/abnormal 3) dysfunction is predicated on statistical norms 4) bioreductionist understanding of impairment i**ts understanding of impairment as objectively defective prior to measurement**

ICF undermines rehab science efforts to enhance the lives of disabled people

Aug 26-29, 2021

Sunday, August 29, 2021
11:53 AM

Engaging with Carol Bacchi: Post-structural comparative politics and acknowledging the political effects of research; Malin Ronnblom, 2012

Comparative analysis is impacted by methodology and trying to challenge the prevailing positivistic paradigm - world is already there vs: post-structuralist position: reality is regarded as understandable through constructive lens of the research process

Political significance of methodologies: 1) why methodology matters politically 2) absence of attention to critical and political questions of methodology is existing in comparative studies and FCP 3) WPR suggests how we may to critical feminist studies differently

Methodology matters!

Ontological politics: ontology defines what belongs to the real, conditions of possibilities in which we live; adding politics suggests conditions of possibility not given;

Ontological politics: (when focusing on methodology) we are researchers are shaping the reality we study; and thus has political consequences; **My words: (choice of quant, qual, paradigm, influences what we see and can ask, much like discourses)** each methodology forms a lens limiting our view;

Ontological politics: highlights ways research methods have productive and descriptive and technical effects

Comparison and theological considerations:

Comparative analysis is implicit or explicit part of most research; we should all be concerned about how our methodologies matter in our research; need to scrutinize normative underpinnings; **need to address knowledge production**

Feminism, politics and the political:

Core issue in feminist scholarship: scrutinize and challenge dominant understanding of science and knowledge prodtion (WRP does this)

Double mission to challenge WHAT to reearch and HOW to carry it out; what are the political implications of our research practices;

To **answer positivistic position** on objectivity needs a strong objectivity; for research to reveal "reality enough to stick in the right method: BUT strong objectivity is relative to most problems; **features of positivistic position; failure to acknowledge context of discovery: not only the object of the research but the researchers themselves and how they formulate study at hand needs to be scrutinized in the research process**

Concept of objectivity as already there vs role of research itself shaping how reality is understood; challenges position that research on politics is not political

Political: dimension of antagonism constituting human societies:; conflictual dimension of the political 1) important to understand what is at stake when discussing the political ; political is conflictual - opposition and conflict

Politics: set of practices and institutions through which order is created; politics as a field of research;

Questions to be politicized: 1) articulated in collective vs individual 2) placed on public agenda 3) articulated in terms of conflict (**highlight element of power rel'n in society and create opportunities for change)**

Foucault: power and knowledge inherently related: claims on the part of the researcher need to be understood as a way of producing the world and truths about it; ontologies matter;

- **What kinds of truths are produced through conventional approaches of comparative politics and what kind of effects could result?**
- **Thoughts on how to do comparative politics diifferently without reinforcing political status quo (Is this possible? To move outside discource???**

Conventional comparative politics:

Mainstream: comparative politics with central presuppositions;

Social Constructivist: challenge positivistic approaches BUT: not visible in most conventional approaches

Basic presuppositions in field: comparison about analysing variables in preferably lg number of cases; evidence of positivistic position; Role model for traditional comparative politics lies in natural sciences - testing, ranking, measuring + causal explor; research about fact finding and right solutions

Seem to acknowledge impossibility to conduct this approach to natural science BUT proving scientific value "of comparison more important for traditional comparativists than to acknowledge their ideal of science production does not correspond with possibilities available in social science;

Normative understanding of conventional approach: measuring ranking performed against implicit normative backdrop;

The focus on causality and generalizations and fixed categories does not address how rese0arch process itself includes a political dimension

To talk about fixed categories is to take the politics involved in the production of those categories out of the picture;

Governmentality Research: issues of truth production and established definitions of politics dismissed in favour of focus on the conduct of conduct: focus where we are seen to govern others and ourselves according to various "truths" regarding our existence and behaviour as human beings;

Feminist Comparative Studies:

Detaching multi-method approach from epistemological and ontological considerations; methods as neutral tools to be combined; political implications; multi-method approach possible d/t unquestioned acceptance of positivist presuppositions

We need a core discussion of our assumptions and goals when doing research; methodology matters; research approaches shape how we encounter reality and hence are inherently political

Transformative feminist approach:

Would bring different questions both to WHAT we study when we study politics, HOW this is done and what kids of political implications this brings;

Feminist comparative studies seem to want to join this "male" stream of gender studies; endorsement of multi-method approach due to unquestioned acceptance of positivist presuppositions; need to challenge the aspiration to adjust research to conventional tradition and consequences of this ambition; ignores calls for reflexivity re: episte and onto positions; does not challenge conventional underst of politics and the political

Is the aim of feminist scholarship really to be accepted in mainstream studies, that the mainstream is the setting we need to adjust to; research is about finding out, not having an impact on the shape of the real conditions of the world

Politics behind Feminist Comparative Studies: positivist, stable understanding of gender; descriptive, lacks analytical dimension;

We need a core discussion of our ambition and goals when doing research REFLEXITIVITY

Traditional FCP reproduces the same epistemological and ontological position as conventional comparative politics; they fail to acknowledge their positioning as part of research and miss out on how they themselves shape what they research

WHAT IT THE ALTERNATIVE???

Comparing problem representations:

Methods are polical: create different perceptions concerning what counts as reality and arise out of different political positions; suggest a different form of comparison offering a new position on what to compare and hot to undertake the new comparison:

WPR: policy as produced and in the making; possibility of comparing problematizations; shifts focus to how (gender equality) is filled with meaning in once context:
Examples of universities 1) lack of qual women in position 2) lack of women in higher positions 3) waste of human resources => compare these and processes leads to deeper understanding of problem; destabilizes scientific normative representation of (disability) equality

Key: to avoid fixing things to be compared => challenge traditional comparative methodology

One of the greatest challenges in WPR Is quest 4 to id silences: unless you find a way to challenge fixed categories much crucial in comparison studies goes missing;

Post-structural questions:

How have we come to this?
How have we become certain kinds of researchers?
Where has the longing for real science come from?
Why are some comparative politics and some feminist political scholars so resistant to post-structural chellengs?

Political? Lg involvement of researchers as advisors on international committees such as EU?; where "good useful research" applies to EU agenda and central to neoliberal governing (of universities) today

We need to situate ourselves in research and important to be clear about where the analytical position of our research leads us. How do we produce politics? Political realities give shape; scrutinize what is taken for granted BUT what is the lens we ourselves are using ???

31/08/2021

Sunday, August 29, 2021
11:53 AM

Effects of stigma on therapeutic relationships Zubair, 2015

Stigma-combination of social stereotypes and personal attributes associated to endorsement of inferior and "unacceptable human characteristics; the person is unfairly treated compared to the non-stigmatized group

Metsdagh + Hansen, 2014; **commencement of psychiatric treatment initiates the process** whereby individuals are negatively labelled as irrational, unstable emotional state, incompetent, worthless and potentially dangerous to self and society. **BUT psychiatric tx is the medical model of disability created by us, so are we creating stigma? What if MI is viewed from a different lens, would stigma still arise?**

MHP should used patient-centred humanist principles - does this include not wanting medication?

The therapeutic relationship and the consumer:

The **therapeutic relationship is where the hcp are trusted to understand the clients and support them to recognize their own needs** and gain empowerment in life -> recognize needs? Medical model of disability

Establish quality relationships is often compromised and most ppl with MI report lack of empathy … medical model only option or result of time limitation and productivity of Western society?

Professionalism and overprotectionism : wide practice by hcp to enforce meds and tx options BUT patients want to be like everyone else (not needing tx); by looking at problem as stigma, are we ignoring other possible causes of the medical model of MI prescribing meds and tx?

The stigmatized experience impairs the therapeutic relation and then driving force for individual to embrace strategies including secrecy and withdrawal to **avoid negative interaction with hcp - is this because the hcp wants to push medication and tx?**

Fear of being labelled/discriminated: decreased useage of mental health services and tx options

Many hcp disapprove of mh consumers and considers them a failure; consumer feels rejected and judged;

Recovery is a fundamental goal of mhs but hindered by stigma; recovery implies that the MI person is not good the way they are and they have to do something to become "good" like everyone else; Recovery as a goal of mhs implies the belief that medical tx is the solution;

Stigma - adversely affects therapeutic relation, stigmatized mental health care providers behaviour: decrease PT outcome, decreased client satisfaction, withdrawal from health services, increased risk of physical illness and increased mortality rate: what is medical model and its implementation individualizes problem and this goes against peoples' feeling of validation?

Recovery based practice should be established where tx and rehab should be provided to the pt who should also be able to communicate assertively to boost self esteem;

Hcp should not only focus on individually based intervention but values and context is a significant part of effective tx

05/09/2021

Sunday, September 5, 2021
11:24 AM

Mainstreaming politics: Gendering practices and feminist theory, Carol Bacci & Joan Eveline, (2010)

Ch 1:
It is impossible to script reform initiatives: fields of contestation are shaped by on the ground political deliberations and practices

Fixing meaning: makes us forget the **effort in meaning-making activities**

Discourse: struggle over meaning takes place here; calls truth-status into question; institutional knowledges allow some knowledges to be dominant discursive practices

Subjectification: **individuals don't pre-exist discourse but are the effects of discourse**; which practices make (disability) happen?

Policy workers: often lacking institutional authority; deadline driven nature of bureaucratic work practices meant policy workers often lacked time and space for reflect on constitutive dimension of policies

Need to focus on unequal power relations: for real change to take place (in womens/disabled) lives men/able will also need to change

Critically important to avoid trap of developing "one size fits all"

Deep evaluation: 1) id ways gender/disability is a process vs character of person 2) way policy produces gender/disability 3) masculine/able forms of seeing and doing sustains gendered politics of advantage 4) broad conceptual factors impinge on transformational visions

Ch2:

Focus on impact - cannot question neoliberal premises; effective implementation requires focus on policy's creative role in constituting problems and shaping gender relations; need ex-ante vs ex-post analysis

Neoliberalism: advocates for decreased size and regulatory mechanisms of state OR projects to construct a particular kind of states; **must have watchdogs - without them equality drowns in the stream BUT if they are necessary, how natural a process is this? Neoliberal regimes about facilitating business activities**

Workplace culture must change to accommodate those who are different

The suggestion that difference should be recognized supports the ontological view that attaches a biological characteristic to humans instead of focusing on the politics that privilege some and de-privilege other characteristics

Ch 3:

GAP: major goal is to id factors that could create gender analysis is a long term process of emergent changes to asymmetrical power relations; important to involve policy workers; social change should be seen as unpredictable effect of complex and continuous process;

Need to challenge policy proposals; difficult to implement given pervasive influence of established bureaucratic conventions in shaping those proposals

Time constraints imposed by neoliberal management practices

Ch 4:

Gender/disability is a contested concept and can be defined in ways that reproduce or in other ways that decrease inequalities;

Importance of context: what works in one situation may not be possible or may not have same effects elsewhere; need to bring attention to disabling institutions

Treating unequals equally simply reinforces inequality

Dilemma: addressing wome's/diabled needs to differences approach can entrench status quo; womens/disabled lives will not change until mens/ables lives change

Ch 5:

Policies: discursive practices that produce and reinforce specific categories of social being and specific patterns of social organization and we must not focus on identity categories **but to acknowledge identity categories when people inhabiting category deems politically necessary; Cake and eat it too? Move in and out of socially created categories???**

Need to have reflexive self-scrutiny: aimed at researchers and policy workers as we're located social subjects

Social Constructionism (social product vision) emphasizes extent to which our understandings of the world are products of social bias

Post structuralism: power is involved in producing forms of knowledge; categories have no essential/transient historical meaning

Feminist body theory - effects of representations as opposed to "real"
Governmentality Approach - broader understanding of government to include institutions, agencies, professionals, researchers, experts

Gender analysis frameworks: not stable but malleable and subject to continual pressures reflecting changing context

Project trap: constrained transformative potential of analysis due to subservience to wider policy objectives

Ch 6:

Policies elicit subjectivities vs determine them; political subjects are both those who do policy and those to whom it is done; this includes the researcher

Post structuralism avoids generalization

Discourse is relatively well-bounded areas of social knowledge both constraining and enabling what can be written, spoken and thought

Poststructuralism - fluidity of meaning ontological becoming

Power is tolerable only on the condition that it masks a substantial part of itself - its success is proportional to its ability to hide its mechanism

The true power of policy is its power to form us; policies cannot occur without actions of agents/subjects - to what extent does this claim make policy actors responsible for the effects of policy?

Discourses must be recognized as practices with no suggestion of intent

Policy workers are not passive dupes of bureaucratic and hierarchical organizations BUT poststructuralism say they and everyone is governed by discourses where they work

Most powerful discourses: institutions, law, medicine; agents are constituted through the work they do

Reflexive practices: we're inside the processes we're examining

Reflexive turn: academic theorizing arose from increasing realization that researcher/theorist plays and active role in constructing reality being investigated**; (no escaping discourse!!!)**

WPR: policy makers need to recognize how policies produce specific understandings of problems

Knowledge: not just know-how but social, historic and political conditions under which statements are seen as true or false

Post structural meaning can only be fixed temporarily

Ch 7:

Can't change gender inequity pay gap without considering understanding and social conditions and dev't and that key players see relevance of pay inequity to their agendas; need to increase awareness of ongoing procedures that produce inequality

No one cause of inequity (and therefore no one solution); factors are not fixed but reshaped with changing economic, and political forces that change over lifecycle

Ongoing process vs sense of completion: must necessarily be sustained as long as polity making endures

Ch 8:

Major deterrent is insider status of those performing analysis as policy workers obligated to perform tasks as laid out by gov't

Consultation is important: bureaucrats demonstrate accountability by engaging with the community 2) policy units inside gov't - confirm to rigid structure vs escaping bureaucratic restrictions 3) ethical - stay in touch with public opinion

Ch 9:

Commatization: policy emphasis goes into disadvantages leaving advantages available to the unspoken norm

Bureaucracies normalize their practices though formal and informal rules

Ch 10:

Highlighting gender/disability as primary category will have similar effects in differing cultures is contentious

WPR; based on understanding that events can be understood adequately only if seen in relation to specific locales; inquiry is fluid of context vs specifying in advance all the research would involve; data will tell us how, when, where to augment or change direction

Divisions between categories don't exist but practices that divide do

Process must: map institutional processes through which inequality is reproduced; show policy makers how their work is involved in the production of inequality; avoid rhetorial entrapment in attempts to convince polity actors to soften the critical edge and endorse pure business. Case perspective: Goal is to reshape practice vs focus on policy makers attitudes and values

Ch 11:

Bureaucratic conventions: not simply impediments to change also subjectivising effects; need to bridge chiasm b/w policy dev't at gov't level and implementation of specific organizational contexts

Collaborative research is contextually medicated;

Sensitivity to internal politics affecting research partners is crucial

Western bureaucracies: structured in drive for increased performance and efficiency; need for relevance impacts funding and 3-4 yr political terms; regular restructuring and workers under confidentiality codes

Fine balance between insider knowledge and outsider objectivitiy - and danger of harm to research partners

Ch 12:

Collaborative practices: best hope for long-term learning and commitment

Organized hierarchies of decision making use dominant systems of thought which make extablished/normal ways of seeing and doing seem the correct or only way - favours entrenched groups

Managing diversity practices prioritized business interests over employee equity but individualizes problems of groups disadvantage while resting ojn insecure ground of voluntary business case driven initiatives

Policy analysis - acknowledgement of relevance must become organizational vs individual issue

Entranched management ensures product of policy actors with generic tool kits, guides and training materials and leaving to the individual to work out to use effectively the local context if able to "fit it in

Ch 13:

Any reform initiative may be taken in unintended directions; therefore must pay more attention to practices, processes and procedures associated with developing initiatives

Doing the document is a critical part of doing the change (frequent training by SLF for front line workers to do policy

Need to challenge conceptions of groups constructed as homogeneous with fixed boundaries; difference is only in relation to something else

Need to be willing to hold categories in abeyance until those with greatest needs are heard (doesn't this create another category?)

Politics of movement - decisions about fixing and unfixing meanings needs to be made in specific locales at particular times by the participant in collaboration and based on reflexive judgement

Researchers must acknowledge political investments in research practice; difficult when evidence-based policy requires objective knowledge BUT knowledge is inherently political and policy problems accrue meanings that could be otherwise creates impetus for research as political practice and current practices of university researchers: similarities in circumstances facing academics and policy workers: severe time constraints, underfunding and burgeoning administrative demands

02/10/2021

Saturday, October 2, 2021
11:43 AM

Submitted Q1-6 to lynn for review; response returned suggested providing a snap shot summary of each question to ensure clarity and then to provide my response to Ques 7:

Remove the "commensurate" level of employability after the 2 yr point of disability, to ensure that those able to work at this level do not lose their benefits. Additionally, when employees are well enough to return to the workforce to allow for work at the level of their ability while remaining eligible for disability benefits.

07/10/2021

Thursday, October 7, 2021
8:19 PM

Summarize quest 1-6; working on Ques 7: my solution:
Need to investigate further challenging or resisting problematization of medical model of disability;

Challenging the Medical Model - need to find articles to support that we are not challenging to argue pros and cons but to question…also, by challenging something, does this not imply that we accept it as real and therefore now reading article on resistance..

18/10/2021

Monday, October 18, 2021
12:12 PM

Dispersed resistance: unpacking the spectrum and properties of glaring and everyday resistance. Lilja and Vinthagen, 2018

Need to develop an argument for challenging problematizations

20/10/2021

Wednesday, October 20, 2021
8:58 PM

Working on summarizing responses to question 1, 2 and 7

23/10/2021

Saturday, October 23, 2021
10:48 AM

What's the problem represented to be?

Lack of medication, counselling or medical treatment

30/10/2021

Saturday, October 30, 2021
2:59 PM

Ques 7;

1. What is the problem represented to be?

A lack of engagement in occupation causes WPMH issues and engagement in occupation reduces WPMH issues

2. Answering question 2 of my own problematization I have taken articles from my proposal to start off. If more is needed I will search for this later.

Question 2 is "What presuppositions or assumptions underlie this representation of the problem?"

Desrosiers, 2005; Participation and Occupation

Role of **meaningful activitie**s and engagement in the environment as important indicators of well-being and health
Satisfaction and participation is more positively related to quality of life than participation itself; **satisfaction with engagement in occupation is more related to subjective quality of life than the level**

of engagement itself; therefore personal subjective judgement is a determinant of quality of life and leads to long term health

Satisfaction with social roles is more important than satisfaction with daily activities in relation to quality of life

Participation in social roles is less restricted by health problems than participation in daily activities

Durocher, Gibson + Rappolt, 2014: Occupational Justice: A Conceptual Review

As a belief that participation in occupation can affect health, occupational justice is underpinned by belief to engage in diverse and meaningful occupations to meet people's individual needs and develop their potential. Barriers to engagement in meaningful occupations are injustices

Values attached to occupations are dependent on cultural and socio-political determinants

Occupational justice: meaningful and purposeful occupations (tasks and activities) that people want, need and can do considering personal and situational circumstances; gives individuals right to equal opportunities to engage in varied and meaningful occupations to meet basic needs and maximize potential.

Social structures can lay determinants of occupational justice

Occupational disruption -> temporary absence due to illness

Occupational rights (Hammell, 2008)

Need to delineate **relationship between occupational and social justice**; they are linked but the former emphasizes individuals occupational needs, habits and capacities and that participation in meaningful occupation impacts individual and community health

Hocking, 2017: Occupational Justice and Social Justice: The moral claim for inclusion

Whether working toward occupational justice can contribute to realizing a just and inclusive society

Occupational justice complements social justice; 1) a just society treats people equitably 2) all citizens fair share of societal resources

It is society's responsibility to preserve people's health

Social justice is concerned with a contract between a society and its members setting up conditions within which citizens live and interact

Capability Theory: well-being is not a matter of what people have - what they are able to do

Because societies could act top protect, nurture and restore people's capability to be healthy through fair distribution of the determinants of health disparities are justice issues

1. Humans are inherently occupational and this is a determinant of health
2. Occupation is structurally embedded; structural factors and personal characteristics are determinants of occupation
3. Engaging in occupation can improve lives of people in vulnerable situations

Social conditions giving rise to occupational injustice can be changed

Occupational justice - multiple equally legitimate ideas, traditions and ways of life shaping peoples occupational patterns, standards and performance; some established patterns may be inherently unjust; breach of occupational justice; when participating in health-enhancing occupations is inequitable across different groups in society

Occupational Injustice is purported to undermine economy, wasting human potential and creating a health burden

Occupational Scientists claim **occupation as a right**; health disparities are inequitable and occupation can be considered a right as socially determined and occupational inequities can cause real harm

Lack of real access to work was depicted having negative psychological and social impacts
People in vulnerable circumstances s worthy of social and occupational justice
Root cause of occupational injustice - policies among others; addressing how wrongs could be put right: attention to human rights, policy development and change in policy structures and advising policy makers of unintended outcomes of legislation
Occupational justice aligned with or derivative of social justice
Difference between participating in society and participating in occupation; focus on what people can do and be versus what they receive

Loisel, 2005: Prevention of Work Disability Due to Musculoskeletal Disorders: The Challenge of Implementing Evidence

Returning disabled workers to work - many challenges to employers, employees, health care providers and insurers; complexity with multiple legal, administrative, social, political and cultural obstacles; Interventions involving diverse stakeholders in the workplace can improve RTW; role of the media important in RTW attitudes and fears
Patients, physician, insurers supported **early RTW for positive health effects**
RTW interventions should be targeted at different levels of the social system; challenge of relations between researchers and policy makers; GRTW requires actions and decisions by patients, physician, employer occupational health, 3rd party payers each with their own values, objectives, interests and training
Workplace barriers to RTW - perceived added expense, actions and attitudes of in-line management, co-workers, decreased supervisor skills; important to pay attention to workplace organizational factors (disability management practices, policies and procedures) culture, employer/union relations, upper management, health and safety practices, worker legitimacy and dignity
Need an environment of trust for the employer and worker; maintain link with the employer, provision of modified work
Insurer - the insurer may influence intervention process with decreased motivation for best evidence; compensation process may have anti-therapeutic consequences; needing to prove disability may thwart reassuring rehab interventions, reassurance and changing perception; less support of additional interventions (of new diagnoses) due to increased liability
Social - little evidence on effectiveness using research results in policy decision making; different than changing individual professional behaviours to those of policy makers that represent a larger body of political values and organizational strategies that always guide decisions -> any innovation conflicting with these values will not be adopted; they are impacted by medicolegal, laws, regulations, contradictory evidence re: disability prevention and socio-political environment
Most barriers/facilitators to RTW are more related to psychosocial, workplace and management issues than the (physical) disorder; often investigation of disease versus barriers/facilitators to RTW; recommend that disease diagnosis perspective is changed to work disability diagnosis

1. Reassure worker
2. Helping workplaces
3. Coordinate with stakeholders
4. Modify the social context
5. Intervention development and education
6. New avenues - internet
7. Researcher role
8. Common language

Njelesani, 2013; Towards a Critical Occupational Approach to Research

Locate **occupation as a site of knowledge production**
Occupation: doing or engaging in activities
Occupations can be seen as health and wellness promoting or harmful depending on form, function and meanings
Knowledge is produced when people engage in occupations
Occupational perspective assumes occupations have many forms, function and meaning; it is unique because the unit of analysis is occupation; research with this perspective focuses on how occupations are described and understood; it seeks understanding of which occupations are selected, who is engaged and context of them; occupation is an active political site where meaning is generated and contested; knowledge production is different than meaning making; **knowledge production - social production of knowledge re: political and social context of occupation**; meaning making - understanding people's personal subjective experiences when engaging in occupation
Meaning associated with occupations are transient and dependent on context
Must attempt to make taken-for-granted assumptions explicit
Dominant ideologies may create inequalities and limit opportunities
Few studies examine macro-level societal influences and **individualistic perspective is over-emphasized**

Townsend & Wilcock, 2004: Occupational Justice and client-centred practice: A dialogue in progress

Equal citizens in daily lives comprised of health building occupations
Communities shape individuals and groups and individuals and groups shape their communities
OT's can enable people to flourish BUT **professional dominance, standardized treatment and documentation, market driven economies, insurance, laws and political conditions interfere**
Fundamental need to participate in various occupations as empowered citizens
Occupation - participation in daily life
Western conceptions of justice and beliefs about individual autonomy. (is this why the medical model flourishes, because of Western belief in the individual?)
Justice is culturally bound - ideas, beliefs, principles, reasoning re: civic governance and state regulation; equal distribution of rights and good vs trust and loyalty vs exploitation and betrayal
People are occupational and social beings with differing occupational needs, strengths and potential requiring different forms of enablement to flourish
Western view of individual autonomy
Participation (doing, being, becoming) essential to promote health, well-being and social inclusion in contexts
Occupational determinants (unemployment, poverty) create/limit possibilities for occupational justice which in turn complements and extends the understanding of social justice
Occupational Alienation: social condition of injustice vs psychological state; right of individuals and population to experience meaningful, enriching occupations as opposed to alienation: prolonged experience of disconnected, isolated emptiness, decreased sense of identity, decreased expression of spirit, sense of meaninglessness; lack of opportunities/resources is viewed as unjust; different people find different choices meaningful
Occupational deprivation: prolonged preclusion from engagement in occupations of necessity/meaning due to factors outside the control of the individual; may also be limited choice due to location, ability etc.; different from temporary occupational disruptions

Occupational marginalization: need for humans to exert micro everyday choices and decision making power as we participate in occupations; invisible; normative standardized expectations of how, when and where people should participate; participation restrictions (citizenship, justice, health) BUT managerial systems seek efficiencies through standardization such as controlling time, places, policies, laws, funding
Occupational imbalance: population-based term to identify populations not sharing in labour and benefits of economical production: un-occupied, under-occupied, over-occupied; some occupations are valued differently in different locations
OT as profession addresses occupational injustice; OT intentions are overruled by policies and funding priorities; **corporate efficiency models emphasize standardization over attention to justice**

Wilcock, 2007: Occupation and Health: Are They One and the Same?

Occupation and health are inseparable; frequently overlooked by medicine
Occupational science has potential to challenge socio-political policies
Different cultures do not share the concept of occupation as all the things people do
Expression and execution of occupation is learned and modified by the ecosystem and socio-cultural environments in which they live
Lack of action to decrease social illness; poorly understood role of occupation in terms of social, physical and mental health
Importance of what people do, how they experience and feel about what they do, that doing should encompass potential and meaning as well as prerequisites for survival and the interactive nature of doing and belonging can be health giving

Wisenthal et al, 2018: Cognitive Work Hardening for Return to Work Following Depression: An Intervention Study

CWH uses **work as treatment modality** to address occupational challenges facing people RTW after depression
People's perceptions of ability to perform work tasks and meet role expectations is linked to RTW outcomes; **change in self-efficacy is relevant to RTW**
Improved work ability and reduced depression severity; **would this intervention be useful earlier in the RTW process as part of standard care for depression**
Timing of RTW in depression might be improved with efforts to engage people with depression in supported occupation based interventions even before depression has lifted; importance of routine and structure; highlight importance of occupational meaning

World Health Organization, 1986: Ottawa Charter for Health Promotion

Health Promotion: enabling people to increase control over and improve health; health is a resource for everyday life; no just the responsibility of the health sector
Fundamental conditions: peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, equity
Impacts to health: political, economic, social, cultural, environmental, behavioural, biological factors
Health promotion strategies: adapted to local needs and possibility of individual countries/regions taking into account different social, cultural and economic systems
Health promotion policy: requires identification of obstacles to adoption of healthy public policies in non-health sectors and ways of removing them

Socio-ecological approach to health as health cannot be separate from other goals
Work and leisure should be a source of health for people
Rapidly changing environment in areas such as work must be followed by action to ensure positive benefit to health
Health sector must move toward health promotion

08/11/2021

Monday, November 8, 2021
7:20 PM

Examining collectivism by Jongbloed and how this contributed to the medical model of disability

Have addressed welfare state based on income inequality, collectivism favouring the group needs over those of the individual, and respect for authority; need to work on capitalist development versus social entitlements;

Do more reading of Jongbloed, McColl, Steinstra and Samra

Collectivism - normative - dividing practices

10/11/2021

Wednesday, November 10, 2021
7:24 PM

Finished question #2 with all parts;

Now needing to review articles for question #2 to see them "with new eyes" after having responded to the questions and revising them

Rereading Jongbloed

11/11/2021

Thursday, November 11, 2021
2:38 PM

McColl et al:
Disability policy exists to fulfil the role of government toward people with disabilities. We elect governments to enact collective solutions to shared problems in society (Department of Finance Canada, 2006). Governments create disability policy specifically in order to achieve 3 aims (Bickenbach, 2006):
1. Equity – to ensure that disabled citizens are not discriminated against, either willfully or inadvertently;

7

1. Access – to ensure that disabled citizens are able to participate in all aspects of society.
2. Support – to ensure that disabled citizens are able to acquire the goods and services necessary to meet their needs.

In developed societies, one of the key roles of government is to promote equity among citizens in terms of access to goods, services and opportunities.

13/11/2021

Saturday, November 13, 2021
1:40 PM

WPMH - a misnomer? By calling mental health issues specifically WORKPLACE mental health issues; this clearly links mental health with the workplace and possibly business interests; it ignores everyone's mental health issues that are not workers…BUT as I am analyzing disability policies, I have to look only at employees…. Linking mental health with the workplace necessarily results in an assumption that the workplace is able to impact mental health

But I am analysing disability policies that in the Canadian system are specific to employees only; cannot spread too wide; need to stay within workplace mental health

Comprehensive vs cause-based systems show the distinction between mental health and only specific WPMH related to the workplace…

Need to stay within the Canadian system about mental health; not to solve world issues of mental health

Kirby Report - distinguishes the difference between treating physical and mental health

20/11/2021

Saturday, November 20, 2021
1:51 PM

Combining draft version of results Lynn reviewAug:Sept Q1-6, 18:10:21B with Rsults 23102021lsNOv 20 under Results folder

Thoughts: is the medical model appropriate for some conditions and not others?

25/11/2021

Thursday, November 25, 2021
7:28 PM

Rereading articles for question #3;

Have developed practices to "create" the medical model of disability

Applying for disability benefits

Workplace practices of -> encouraging tx seeking
-> automatically assuming that performance issues in the workplace are due to individual flaws, not anything about the workplace, too high demands, or other social determinants

29/11/2021

Monday, November 29, 2021
6:55 PM

Answering question #3: looking at Citizenship involving employment and income as well as the added building block of disability supports;

Ties productive work with disability supports such as goods and services for individuals required for daily living;

Idea of productivity tied to quality of life and the different definitions of disability, do they fit into this paragraph about citizenship?

07/12/2021

Tuesday, December 7, 2021
6:17 PM

Looking at question #4:

Reviewed wikipedia on OECD as well as UN

WHO is part of UN's economic development and humanitarian assistance:

Other global issues include colony independence and environmental programs

What they choose to focus on become global issues, problems and concerns

Need to explain why I chose to examine Sweden and the UN

10/12/2021

Friday, December 10, 2021

11:15 AM

Question #4: What is left unproblematic in this problem representation? Where are the silences? Can the problem be thought about differently?

Intent is to problematize the problematizations and the problem representations they contain to scrutiny; what are the limits in the underlying problematizations? What fails to be problematized?

Raise for reflection issues and perspectives silenced in the identified problem representation

Binaries simplify complex experience. Where does its simplification distort or misrepresent certain issues.

Cross-cultural comparisons can help to realise that certain ways of thinking about problems reflect specific institutional and cultural contexts and that problem representations are contingent. Something is a problem in one context and not in another. RSI in Australia but not recognized in the US…what led it to be an issue in one but not the other?

Sweden and Canada both look at **full participation** in society by disabled persons; and **promoting access/providing opportunities** for disabled; where did **rights based** view to disability come from? Universal Declaration of Human Rights Dec 10, 1948 as response to WWII, threat to nations, peace and security

Problem thought of differently: all or nothing employability in Canada; Sweden has part time work; is engagement in occupation deemed to be solution by Sweden? Therefore lack of engagement in occupation, lack of finances etc. is the problem?

11/12/2021

Saturday, December 11, 2021
1:04 PM

UN focuses on equalization of opportunities - problem of disability then is lack of opportunity

Standard Rules for the Equalization of Opportunities for Persons with Disabilities

Preconditions for equal participation where participation is determined from lens of society

A **precondition** for participation is **awareness** (of disbility), **medical care** and **rehab** (to increase function) and **support services** (to increase function)

Therefore what is left unproblematic? It is taken for granted that awareness, medical care, rehab and support services are needed to support those with disabilities to participate in society; **unproblematic is those with disabilities need assistance to be like the majority; that those with disabilities cannot participate in society without help**

Target areas for participation; by focusing on access to physical env't, information, education, employment, income, family life, culture, recreation/sports, religion we are not looking at the quality of each of these aspects; we are making **assumptions about the value of these things** to people with disabilities as a group - however, "**people with disabilities" is not a homogeneous group**; we are defining what they should value; the Western world makes an assumption that other areas, traditions and cultures value the same things -> **the Western way of viewing the world is unproblematic**

Implementation measures: how the target areas for equal participation should be carrierd out and applied

Monitoring Mechanism: Purpose to ensure effective implementation; **Rapporteur:** relevant and extensive experience in disability issues and international organizations shall be appointed, if necessary, funded by extrabudgetary resources, for three years to monitor the implementation of the Rules. **panel of experts** will be encouraged by the Special Rapporteur to review, advise and provide feedback and suggestions on the promotion, implementation and monitoring of the Rules.

12/12/2021

Sunday, December 12, 2021
3:33 PM

Convention on the Rights of Persons with Disabilities

Purpose: The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. (promotes a Western view of human rights and freedomw)

Definition: Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

18/12/2021 and 20

Saturday, December 18, 2021
10:42 AM

Tosselbro, 2016

Welfare to anti-discrimination and access

Relate this to the article stating that by focusing on disability does not mean discrimination

Silfverheim - Past, Present and Future - comprehensive vs cause-based systems led to different approaches to disability policy and work integration

In a cause based system, the definition of disability would depend on the benefit claimed - CPP-D, LTD/STD, WCB (Withers); definitions would all be different; definitions usually relate to being able to work;

Comprehensive system - definition of disability based on? Medical model and defined by physician? As it does not have to be related to an inability to work, it would free up the "solutions" could be seen differently, such as access to (medical) care, anti-discrimination, housing, leisure etc. As in a comprehensive system, the payor is public and not private, it gives greater flexibility to look at WPMH and takes away the need for all-or-nothing view of work disability

Canadian system is binary; 0 or 100; Swedish gradients; state is paying one way or the other whether the person is at work or not they are paid by the state;

27/12/2021

Monday, December 27, 2021
11:18 AM

Question #5:

What effects are produced by this representation of the problem?

First look at **Discursive Effects** and :

Reading again opening minds 1 + 2

Target groups: health care providers, news media, youth, workplaces: intersectionality with mental health?

Using contact-based education as main venue; but these are persons who have "recovered" from mental illness and gone through the system that looks at the medical model (meds, tx, counselling) and using this contact based lens to "target change" for stigma then perpetuates the stigma that is the result of "needing medical care"

Mental Illness and Employment Discrimination - Stuart, 2006

Work is a major determinant of mental health and a socially integrating force

Exclusion leads to material deprivation, decreased self-confidence, increased isolation and marginalization, risk for mental disability

Modern mental health and rehabilitation models and legislative philosophy of citizen rights and full participation are good - BUT vulnerable to prejudicial attitudes

Modern Mental Health Treatment Philosophy: "To exercise the right to live and work in the community, people need community-based tx and rehab services" - which focuses on people with M I needing treatment to join the "normal" workforce -> this is a dividing practice

If Stigma is the result of social processes it can be unmade

Mental health consumer - who is this??; frequently experience stigma; society has created "the mental health consumer"

"We should put more attention to help people with MI to education and training, as they earn less". Thus the issue for people with MI is a lack of training???

"people do not seek EAP and tx for fear of stigma" Is the EAP and tx therefore causing stigma? The medical model, or our choice of addressing mental illness is leading to stigma?

"Divulging MI - people must do this to request accommodation; must prove that MI limits work capacity - therefore the cause is MI and the solution is to resolve MI as an individual factor

Public Stigma and Self-Stigma: Differential Association with Attitudes Toward Formal and Informal Help-Seeking

Perceived public stigma - less likely for informal help seeking and no impact on formal help seeking

Anticipated self-stigma - less likely for formal help (and less so for psychiatrists versus GP - many doubt effectiveness of psychitric tx); no impact on informal help seeking

28/12/2021

Tuesday, December 28, 2021
12:01 PM

Differential Association of Stigma and Perceived Need; Wong et al, 2018

Start with statement that **mental disorders are among leading causes of disability in the US;** emphasizes that this is an individual problem; that the issue rests with the individual that must recognize that the problem rests with them

For those with **recognized need for tx**: focus efforts on the effectiveness of tx and mental health knowledge

For those with **unrecognized need**: focus on addressing personal negative beliefs about mental illness

Whether recognized or unrecognized need, the person must be shown the connection b/w medical tx and mental illness, that mental illness must be understood the way it is taught in the Western World, and that the personal beliefs of a person with mental illness as needing tx should be seen as "normal" normative and commonly accepted.

Summary insights:

mental disorders are among leading causes of disability in the US

Problem: mental disorders are among leading causes of disability in the US

Solution: treatment

Barrier to treatment seeking: stigma

Our results suggest that initiatives attempting to increase treatment seeking through the reduction of stigma…

02/01/2022

Sunday, January 2, 2022
12:30 PM

Subjectification effects: in addition to consider those on the clients, consider those on the physicians and rehab consultants

Re-read the articles and also look at Withers, 2012; look at Canada's Universal Health Care system: achieving its potential

OM Ch 2: hcp programs: contact-based=> meet the mentally ill person and write a life and recovery narrative; thus goal is to decrease stigma (in order to increase tx); problem is not enough hands-on knowledge of MI and solution is to provide knowledge BUT diminishing effects over time and booster sessions were needed (if the intervention is held in a context that perpetuates stigma, then this booster session will need to be repeated and repeated multiple times)

Programs with skill acquisition had better results with no boosters; helped GP's to increase capacity and comfort in diagnosing (but according to Pattyn, diagnosing causes labelling which increases stigma)

Stuart, 2006:

P 522: employment is an important stepping-stone to recovery and to realize these goals (to live and work in the community), people with mental illness must be able to access community-based treatment and rehab services, safe and affordable housing and access to equal employment opportunities

523: having a **psychiatric diagnosis** can limit career advancement

524: t**o decrease stigma and increase employment equity, organizations need to be proactive in identifying and managing mental health problems**…oxymoron

Contemporary anti-discrimination legislation is based on the social model of disability where disability is the product of societal attitudes and structural barriers vs individual problems (but that is because the medical model of access to treatment is taken for granted and is in the rearview mirror)

Pattyn et al., 2014

Problem: people in need of psychiatric treatment avoid seeking help due to stigma

- Internalized negative stereotypes results in less help seeing from specialists and physicians
- Awareness of public stigma results in less informal help being sought

P 232: **mental illness not readily visible** thus entering psychiatric treatment generally primarily means that people with **mental illness are labelled** (which is linked to cultural stereotypes)

P233: must distinguish between types of formal care providers; increased stigma with specialist versus generalist care and difference for informal care - where informal supports can prevent relapse

P236; many have doubts about quality and effectiveness of specialized psychiatric treatment

We must:

1. Address structural stigma related to the mental health care sector and psychiatrists
2. If stigma is related to seeking GP help then they should screen for mental illness: gatekeeper role
3. Need to acknowledge non-medical specialist care
4. Due to fear of discrimination, increase psycho-education

03/01/2022

Monday, January 3, 2022
1:44 PM

Wong et al., 2018

Mental disorders are among the leading causes of disability in the US; despite availability of effective treatments, more than half of individuals experiencing a mental illness go without needed medical health services

Start looking at lived effects and look at Withers and Contesting Illness

11/01/2021

Tuesday, January 11, 2022
2:00 PM

Finished reading chapter 1-3 Withers - Medical model and lived effects

Looking at poverty, social relationships/stigma and occupational deprivation

Consider role of DSM in creating mental illness and disability as well as Social Determinants of Health

Research is about finding out, not having an impact upon the shape of real conditions of the world (Engaging with Carol Bacchi - Malin & Ronnblom, 2012)

Read Raphael, 2015 about SDH; finish lived effects of the medical model of health;

Then proceed with social/stigma model and use Withers as commentary

13/01/2022

Thursday, January 13, 2022
2:11 PM

If income is the basis from which all other SDH come, then does not taking an occupational perspective to health make sense and helping people to work part time would resolve some issues

17/01/2022

Monday, January 17, 2022
11:38 AM

Answering question #6: How/Where is this representation of the problem produced, disseminated and defended? How can it be questioned, disrupted and replaced?

Goal of the question is to pay attention to the means through which some problem representations (medical model of disability) become dominant (1. academic research, mad studies, 2. medical and rehabilitation professions, 3. media,)

18/01/2022

Tuesday, January 18, 2022
11:47 AM

Why do people with mental illness need to "shed their mental illness identity? Why is MI identity elevated to such importance? Is it the way in which MI results in difficulty managing neoliberal productivity in the workplace and therefore MI identity being representative of who they are because lack of function can be "blamed" on MI?

19/01/2022

Wednesday, January 19, 2022

9:29 AM

What created WPMH as a disability? **Neoliberalism**; why is WPMH as disability treated by the medical model? Because (mental) illness is in the Western world treated by the medical model;

Difference between disability viewed in a functional way and treated medically and (mental illness) that is geared to "repairing" biological structures to function optimally

Categories of disabled versus categories of illness

In looking at the medical/social model of disability regarding mental illness, don't need to use the word disability, as that is clearly in relation to the norm which is contextual and socially bound. Dysfunction is normative, not a natural limitation. As such, we can look to examine the norms to be modified that might impact a persons ability to function in society.

If a function can only be deemed to be impaired in relation to a societally pre-determined norm, the medical/social model of disability is an account of the interaction between the individual and society in relation to the production of limitations on everyday activity. Disability can be seen to be related to our ability to realize our goals and that depends on the match between the environment and our abilities. Disability can also be seen to be related to our goals, which are also a reflection of our past experiences.

If disability is contextual, and socially determined (Withers, 2012) as well as normative (Abouelleil, 2019), it is not absolute, and therefore not objective, but is constructed by the policies that are used to govern society (Bacchi, 2009). With these parameters of disability, it can also be de-constructed.

Any mental deficiency or illness is only thus when it is compared to something. Therefore is it is the reference to which it is compared, or the norm, that becomes important when determining what disability is. Ability or function, and therefore disability and dysfunction exists on a continuous spectrum and it is the context that determines whether it is disabling or not.

In contrast to physical impairments, mental variations are less visible, have a more significant impact on the social rather than the built environment and will require adjustments that focus on social interactions and relationships

The recognition of difference as a matter of social justice; demand for the accommodation of a broader range of variations as a matter of justice

"person should be seen as a candidate for the social accommodation of difference than the medical (individual) correction (treatment) of behaviour - > against prioritization of an individual approach

Society must change to accommodate a broader range of variations in function for social subjects

20/01/2022

Thursday, January 20, 2022
4:18 PM

Beresford & Russo: 2016

Must consider WHO identify as Mad?

They suggest that they must **challenge** long-standing psychiatic dominance, stigma and stereotyping

Looking at recovery and peer support is critiqued for reinforcing neoliberal and martket drive approaches to distress; recovery was to combat stigma and "untreatable" but now used to force people back to work and decrease support; peer workforce has resulted in a decrease in access to professional help and create low or non-paid ancillaries and results in assimilation - not value the experience of service-users (which would lead to increased knowledge of the governed - not beneficial according to Foucault)

Mad Studies are also challenged due to their relation to the academic context which can be seen to be detached from real life issues and individual competitiveness; as well as their focus on experiential knowledge may do the opposite

Possible to protect Mad Studies?

How is it possible to resist and pre-empt Mad Studies from reinforcing and prepetuating the dominant structures of psychiatry as has happened with Oliver's social model of disability that was intended as a force for improving people's lives and the support they receive where it degenerated into an abstracted intellectual exercise and reduced to policy rhetoric

BUT the central focus of Mad Studies is still the "mad" as a thing. It does not question the construct of the mad and how that has come to be. It challenges mad as a thing, just as mental illness, or any other nomenclature.

Look further into Bacchi, 2012 for ideas on Policy as productive; theory as discourse; knowledge of the governed - Foucault

21/01/2022

Friday, January 21, 2022
11:48 AM

Reading Mosleh, 2019 Critical Disability Studies with rehabilitation: Re-thinking the human in rehabilitation research and practice

Lack of interdisciplinary theoretical engagement impacts the type of knowledge produced

Social models of disability often dismiss the lived experiences of disability and fail to theorize the interrelation between disability and impairments.

ICF perpetuates notions of normal and abnormal and reinforces the belief that disabled bodies are inherently problematic and in need of intervention

From CDS perspective, lack of attention to theoretical underpinnings of ICF poses problems for disabled people; explores the production of ability, disability and difference; need to explore the theoretical and philosophical assumptions that maintain and perpetuate ableist thinking

Looks at abnormality as variation from established statistical norms; biological abled body is a statistically generated norm and abnormality is a statistical variation presented as an objective fact

The abnormal body is produced through discourse

Better to recognize difference as a default human condition; move from the normative gaze of ableism to see the inherent beauty of the diversity that characterizes the human body and life itself; need to question the meaning attributed to impairment and ways our understandings restrict what we can become

Rehab Science perpetuates the discourse of normal/abnormal and what bodies are valued in contemporary Western societies;

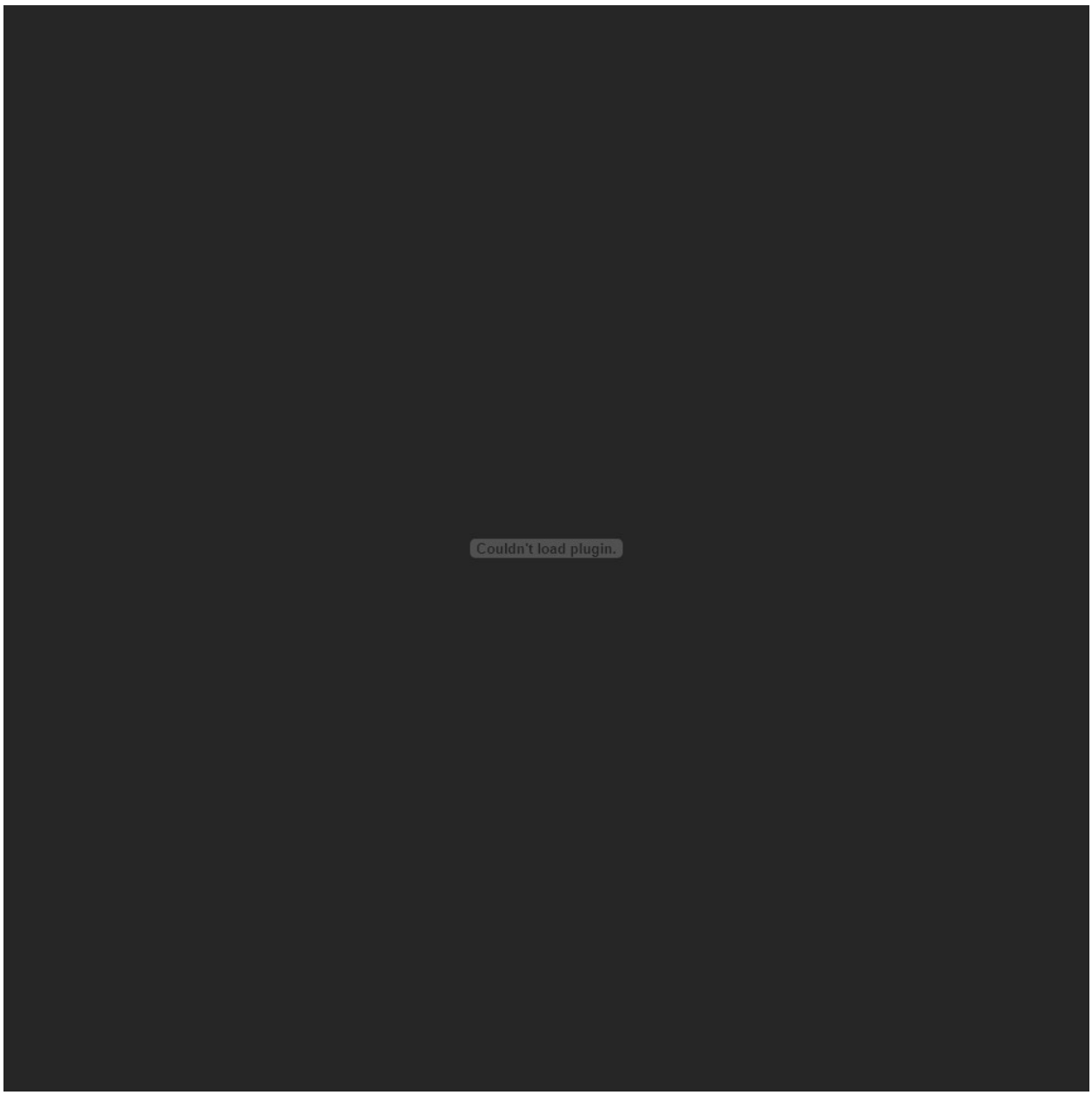
Need to explore tensions as productive opportunities for enhancing rehab practice and scholarship as well as expand the nature of the human

Need to pay attention to the taken-for-granted assumptions that predicate rehab theory and practice

https://laelectrodomestica.files.wordpress.com/2014/07/the-foucault-effect-studies-in-governmentality.pdf

Friday, January 21, 2022
1:14 PM

The Foucault Effect



https://laelectrodomestica.files.wordpress.com/2014/07/the-foucault-effect-studies-in-governmentality.pdf

24/01/2022

Monday, January 24, 2022
12:56 PM

Starting on Question #7 to look how developing my own problem representation

Need to review Bacchi's recommendations as well as my first stab at answer; then I will review dispersed resistance

Comments from Lynn 23/09/2021: has see questions 1-6 but did not want to lead me too much until I have delved into question #7. I therefore started looking at my own problematization of WPMH; first looked through Bacchi, 2009, re-reading, I noted on page 139 the comment "there is always room for **resistance and re-problematization**. The option of refusal is always there, sometimes with deleterious consequences i.e losing access to health services or benefits.

Comments from Lynn 08/10/2022: 1) In light of ongoing data collection, I now need to polish my methods section. The results chapter should not have any interpretation yet. Need to clean up narrative and referenced; tables should go in appendices; Should speak matter of fact; Each section should introduce how the question approaches the narrative to follow; read all the articles and write the results after reading;

2. Write up answers to question 1 + 2 to begin with and Lynn will comment; Flow of thesis will be Ch 1: proposal Ch 2: Methods Ch 3: results/findings/interpretations/insights

3. Ch 4 Discussion chapter; constantly going back to literature; rattle chains and promote social change; what does this mean

Attempt with Ques 1, 2 and 7 sent to Lynn Oct 23, 2021; response received Nov 1, 2021

Comments from Lynn 02/11/2021: use clarity and parallellism for the reader; use first voice; use literature to inform interpretations; bring in literature, but don't integrate;

Comments from Lynn 05/11/2-21: I am the invesatigator; Jan, 2022 next stage

1. Resistance from Bacchi 2009 took me to Dispersed Resistance - Lilja & Vinthagen
2. Thoughts on occupation took me to book occupational perspectves - course where Townsend 2012 is a reference and is also 8th google reference Framework of Occupational Justice and key reference was Townsend, 2012; Townsend also references the Ottawa Charter; Hocking 2012 was recommended by supervisor; I was also looking at an occupational angle when considering my answer to quest 7;
3. Remaining 9 articles from proposal

25/01/2022

Tuesday, January 25, 2022
11:35 AM

https://www.dal.ca/faculty/gradstudies/current-students/professional-development/gradpd.html

Impostor Syndrome 2 March, 2022 1-2 pm

28/02/2022

Monday, February 28, 2022
10:05 AM

Completed results section and sent to Lynn Jan 31. Comments received back on Feb 4.

Aware that I need to clean up my methods section and started this

Discussion with Lynn Feb 10 need to send results section to committee and ques 1-3 sent to them for comments.

- work on methods section week of Feb 14
- Work on question #7 week of Feb 21

Send to Lynn Feb 28

- Work on discussion week Feb 28

Note difference between **providing therapy with a goal of a GRTW** and "providing" the opportunity to continue to **work while unwell and using this as a path to wellness**

Categories:

Discussion (25 pg)

- Short paragraph what discussion is about and what was found

- Restate research problem
- **Aim of study/Categories/Findings:** identification of themes found

- Summarize key findings 1-2 paragraphs
- **Study Findings in relation to previous literature**: consistency of findings with literature; explain how I will divide up this section, categories I will do this under

- Interpret results (follow structure of results chapter)
- Compare to existing research; contrast; contribute; other explanations?

- **Actions to support WPR methodology:** explanation of what I did and how I did it; my contributions and next actions; suggestions for organizations, employees

- **Strengths and limitations**: In short, the study did the following; **future research directions; contributions to occupational science/therapy; limitations of the research**

5. **Recommendations for implementation and future research**

6. **Final Reflection and Conclusion;** Summarizing what I found and why it is important as well as messages from the findings; **involve individuals in occupation as a path to health etc**

Alternate categories:

Restate research problem and questions (compare with intro)

Summarize key findings 1-2 paragraphs

Interpret results (follow structure of results chapter)

- Compare to existing research from the literature review: contrast; contribute; other explanations?

Study limitations

Recommendations for implementation and future research

- Practice
- Education
- Research
- Policy
- Social change

Concluding Summary (ensure flow with beginning of chapter)

The discussion chapter is where you delve into the meaning, importance and relevance of your results. It should focus on explaining and evaluating what you found, showing how it relates to your literature review and research questions, and making an argument in support of your overall conclusion. There are many different ways to write this section, but you can focus your discussion around four key elements:

- Interpretations: what do the results mean?
- Implications: why do the results matter?
- Limitations: what can't the results tell us?
- Recommendations: what practical actions or scientific studies should follow?

There is often overlap between the discussion and conclusion, and in some dissertations these two sections are included in a single chapter. Occasionally, the results and discussion will be combined into one chapter. If you're unsure of the best structure for your research, look at sample dissertations in your field or consult your supervisor.

Summarize your key findings

Start this chapter by reiterating your research problem and concisely summarizing your major findings. Don't just repeat all the data you have already reported – aim for a clear statement of the overall result that directly answers your main research question. This should be no more than one paragraph.

Examples

- The results indicate that…
- The study demonstrates a correlation between…
- This analysis supports the theory that…
- The data suggests that…

Give your interpretations

The meaning of the results might seem obvious to you, but it's important to spell out their significance for the reader and show exactly how they answer your research questions.

The form of your interpretations will depend on the type of research, but some typical approaches to interpreting the data include:

- Identifying correlations, patterns and relationships among the data
- Discussing whether the results met your expectations or supported your hypotheses
- Contextualizing your findings within previous research and theory
- Explaining unexpected results and evaluating their significance
- Considering possible alternative explanations and making an argument for your position

You can organize your discussion around key themes, hypotheses or research questions, following the same structure as your results section. You can also begin by highlighting the most significant or unexpected results.

Examples

- In line with the hypothesis…
- Contrary to the hypothesized association…
- The results contradict the claims of Smith (2007) that…
- The results might suggest that *X*. However, based on the findings of similar studies, a more plausible explanation is *Y*.

Discuss the implications

As well as giving your own interpretations, make sure to relate your results back to the scholarly work that you surveyed in the literature review. The discussion should show how your findings fit with existing knowledge, what new insights they contribute, and what consequences they have for theory or practice. Ask yourself these questions:

- Do your results agree with previous research? If so, what do they add to it?
- Are your findings very different from other studies? If so, why might this be?
- Do the results support or challenge existing theories?
- Are there any practical implications?

Your overall aim is to show the reader exactly what your research has contributed and why they should care.

Examples

- These results build on existing evidence of…
- The results do not fit with the theory that…
- The experiment provides a new insight into the relationship between…
- These results should be taken into account when considering how to…
- The data contributes a clearer understanding of…
- While previous research has focused on *X*, these results demonstrate that *Y*.

Acknowledge the limitations

Even the best research has some limitations, and acknowledging these is important to demonstrate your credibility. Limitations aren't about listing your errors, but

about providing an accurate picture of what can and cannot be concluded from your study.

Limitations might be due to your overall research design, specific methodological choices, or unanticipated obstacles that emerged during the research process. You should only mention limitations that are directly relevant to your research objectives, and evaluate how much impact they had on achieving the aims of the research.

For example, if your sample size was small or limited to a specific group of people, note that this limits its generalizability. If you encountered problems when gathering or analyzing data, explain how these influenced the results. If there are potential confounding variables that you were unable to control, acknowledge the effect these may have had.

After noting the limitations, you can reiterate why the results are nonetheless valid for the purpose of answering your research questions.

Examples

- The generalizability of the results is limited by…
- The reliability of this data is impacted by…
- Due to the lack of data on *X*, the results cannot confirm…
- The methodological choices were constrained by…
- It is beyond the scope of this study to…

State your recommendations

Based on the discussion of your results, you can make recommendations for practical implementation or further research. Sometimes the recommendations are saved for the conclusion.

Suggestions for further research can lead directly from the limitations. Don't just state that more studies should be done – give concrete ideas for how future work can build on areas that your own research was unable to address.

- Further research is needed to establish…
- Future studies should take into account…

What to leave out of the discussion

There are a few common mistakes to avoid when writing the discussion section of your dissertation.

- Don't introduce new results – you should only discuss the data that you have already reported in the results chapter.
- Don't make inflated claims – avoid overinterpretation and speculation that isn't supported by your data.
- Don't undermine your research – the discussion of limitations should aim to strengthen your credibility, not emphasize weaknesses or failures.

Checklist

- I have concisely summarized the most important findings.
- I have discussed and interpreted the results in relation to my research questions.
- I have cited relevant literature to show how my results fit in.

- I have clearly explained the significance of my results.
- If relevant, I have considered alternative explanations of the results.
- I have stated the practical and/or theoretical implications of my results.
- I have acknowledged and evaluated the limitations of my research.
- I have made relevant recommendations for further research or action.

In the discussion, you explore the meaning and relevance of your research results, explaining how they fit with existing research and theory. Discuss:

- Your **interpretations**: what do the results tell us?
- The **implications**: why do the results matter?
- The **limitations**: what can't the results tell us?

01/03/2022

Tuesday, March 1, 2022
1:10 PM

Thoughts for structuring Discussion chapter:

Background/Intro:

Case Management - aim of research to obtain information about the policies and procedures that shape the practice boundaries of RC's as they work to achieve goals of WDP, WI and DM which is a RTW.

Mental Health - medical, treatment issue; social concern and economic problem

Canadian Context: 1) create working conditions supporting ee's with WPMH 2) decrease stigma in WP with an overarching economic goal to be among economic leaders globally

WDP, DM and WPMH - mental health not part of process in developing these programs

Insurers - RC's operationalize the benefits offered by these stakeholders

Context - impacting how RC's operationalize WDP, DM

WPR - needed to as to how the policies shape WDP, WI and DM

Literature Review:

WPMH -

- Lack of treatment
- Lack of psychologically healthy workplaces
- Lack of engagement in occupation; CWH
- Lack of support from insurers, policies and benefits
- Lack of clarity on disability - medical or social

“How are the work integration activities of rehabilitation consultants shaped by the insurance policies purchased by employers in Canada?”

The questions that informed this research are: **“How do disability policies purchased by employers in Canada influence disability management (DM) and return to work processes?”**, **“How is WPMH envisioned in these disability policies ?”** and **“How do these disability policies impact those with WPMH?”**. **The overarching aim of questioning these policies is to open up possibilities of seeing DM differently, with an aim toward social justice.**

02/03/2022

Wednesday, March 2, 2022
9:44 AM

Working on discussion: Interpretation

Interpret results (follow structure of results chapter; what do the results tell us?)

- **Actions to support WPR methodology:** explanation of what I did and how I did it; **my contributions and next actions; suggestions for organizations, employees**

- The meaning of the results may seem obvious to you, but it’s important to spell out their significance for the reader and show exactly how they answer your research questions. The form of your interpretations will depend on the type of reserch, but some typical approaches to interpreting the data include:
    - Identifying correlations, patterns and relationships among the data
    - Discussing whether the results met your expectations or supported your hypothesis
    - Contextualizing your findings within previous research and theory
    - Explaining unexpected results and evaluating their significance
    - Considering possible alternative explanations and making an argument for your position

You can organize your discussion around key themes, hypotheses or research questions, following the same structure as your results section. You can also begin by highlighting the most significant or unexpected results.

- In line with this hypothesis
- Contrary to the hypothesized association
- The results contradict the claim of…that
- The results might suggest that X. However, based on the findings of similar studies, a more plausible explanation is Y.

Intro and literature review:
Impact of RC's on employment outcomes post disability
Gaps, barriers and opportunities for RC's to support delivery of WI and DM
Benefit plans offered by the insurer
RC at the intersection between employee, employer and health care practitioners
Involvement in occupation is healthy but is it used by RC's?
This study aims to add to the literature about RC's and to bring more clarity about WPMH and WI.

Question 1: (what's the problem presented to be?)

Medical Model of disability and WPMH is based within norm-based, neoliberal, production-oriented standards of the Western workplace. Solutions to deal with thusly defined disability and by implication, the absence of health, is to provide medical treatments and "healthy" workplace practices to "help" the disabled individual return to the norm defined productive individual. This does not question the artificially defined norm of the productive employee.

Question 2: (presuppositions and assumptions)

Welfare state with income inequality - neoliberal focus on productivity - medical tx for productivity
Collectivism - group needs over the individual - medical tx for greater good
Respect for authority - physician authority - using medical lens
Capitalist development, not social entitlements - medical tx to meet capitalist goals
Supportive disability policy environment - goals of full participation and inclusion - availability of assistance for disabled
Workplace practices - examine impact of mental health on productivity vs vice versa - assitance/supportive work practices to the individual to return to productivity
Comprehensive vs cause-based systems - Cdn cause-based systems - does not question access to services being lined to employment in disability policies

Question 3: (representation of problem coming about)

Access to disability benefits - is the "problem", not the quality of such
Workplace lens - decreased productivity becomes focus - solution is medical tx for medical problem
WI/DM practices - RC's are the bridge to productivity - through medical tx
Data Collection - focuses on/creates category of disabled - to aid in provision of medical tx
Full citizenship for disability supports, employment and income - access to generic programs and services to be a full citizen
Universal health care - availability of medical care -

Question 4: (What's left unproblematic; where are silences?)

Full participation in society (accessibility, education, employment, income, social security, family life + personal integrity, culture, recreation - sports and religion) - through awareness, medical care, rehabilitation, support
(**Human rights perspective)**
Lack of access to the community of disabled persons
Work as a signifier of participation in community
Comprehensive/caused-based systems - Disability medical issue not normative full-time work

Question 5: (Effects produced)
Discursive Effects:
Stigma discourse
Full time employment/productivity discourse

Sufficient access to treatment discourse
Subjectification Effects:
The disabled
Physicians
Rehab Consultants
Lived Effects:
Poverty/Standard of Living/Lack of Income
Social relationships/Stigma
Unemployable/Occupational Deprivation
What is likely to change?

Question 6: (where is representation produced, disseminated, defended? How to change?)
Media
Rehabilitation/institutions
Research - Mad studies
Spectrum of Madness
Target Audience - everyone

Question 7: (My own problem representation)

- Lack of engagement in occupation is problem behind WPMH
- **Presuppositions** of value of the individual, work for pay, ignoring the unemployed, retirees, seasonal workers, stay-at-home caregivers, youth
- **Come about** through OS and work is healthy but in context of any work, not just remunerative; focus on work as goal and work as therapy
- **Left unproblematic**: medical model of disability; colonized, immigrants, unemployed etc.
- **Effects produced**: include both mental health and physical; decreased stigma?; lob loss for hcp; decreased pharmaceutical revenue; blamed insurers and employers as well as social net for others
- **Produced, defended, disseminated?** Through OS and research; knowledge transfer

Importance:
Hypothesized association of mental health with medical care and healthy workplaces has resulted in research and practice initiatives focusing on problem identification and solutions that take the medical model for granted. The problems have instead been defined as

Focus: decreased productivity, increase medical tx
unsupportive workplaces, increase supports in the workplace
access to benefits, will increase receipt of medical tx
thus the focus of research etc.

03/03/2022

Thursday, March 3, 2022

1:55 PM

Discussion

Interpretation: what do the results tell us?

That the **Canadian workplace** is neoliberal, productivity-oriented
It is based on norms and those falling outside of those norms are in need of assistance to reach this level of productivity - which is norm-based an societally produced, as is then disability - defined as an inability to meet the standards of the norm

Those unable to work apply for **disability benefits** and qualify based on the all-or-nothing definition of disability that is norm-based
Once qualified, individuals are able to access **medically supported treatment** to return to the production-oriented workplace. Focus is sometimes to create a **psychologically healthy work** environment to keep people there. **EAP** and other supports such as **counselling** and **medication** are offered to support these individuals in this work environment

Medical model and its perpetuation as well as setting limits on interventions (solutions) provided

- **If we don't question the socially created definition of disability - defined within the neoliberal productive workplace AND the medical model of disability - that guides and limits the "treatment options" available to those so deemed disabled we are bound to recreate the past and history will repeat itself**

Occupational lens - a focus on health versus illness turns the disabled in need of medical intervention to be like the norm into individuals with variations on engagement in occupation

09/03/2022

Wednesday, March 9, 2022
4:21 PM

Occupation-based intervention - different types? Work-focused and therapeutic with other goals - ADL, transitions

Occupation based intervention in Sweden - engagement in work?

Occupation based interventions - model - Waerens, 2022

22/03/2022

Tuesday, March 22, 2022
10:48 AM

Submitted Discussion - looking at the tool of occupationally appropriate engagement as another resource for health

Worked on question 7 revision before sending to committee; looked at developing my solution to the problem of WPMH issues; lack of engagement in appropriate occupation is reason behind WPMH and thus provision of appropriate occupation is solution

Looking at ways forward as a pilot study with the insurers identified to look at feasibility; look to partner with Swedish researchers to explore how their system works; do more research into occupation-based tx

Now working on methods and methodology corrections after response from Lynn

24/03/2022

Thursday, March 24, 2022
1:44 PM

Discussion with Lynn:

Finish methodology/methods section and send to her. Then work on an abstract, followed by Introduction.

Lynn will have question 7 done for me by the end of the weekend and I can then send to the committee for comments.

28/03/2022

Monday, March 28, 2022
9:53 AM

Realization in keeping reflective journal: most of my thinking was done in the early morning and developed as I wrote.

Major decisions were to follow up on the article by Lilja and Vinthagen on resistance that came from reading Bacchi; this was done in October, 2021

The thought to follow the use of occupation as a means to health and marry that with how RC's are impacted by disability policies evolved as a tool that RC's then can use which currently is not available to them except under the very limited guidelines in the policies which is a time limited GRTW (this is referenced in Pomaki, 2010)

Currently working to edit methods and methodology

Response from Lynn with question #7; need to work on that after finished with Methodology

30/03/2022

Wednesday, March 30, 2022
10:53 AM

Continuing to work on methods/methodology; struggling to keep everything in the present tense; trying to go through first to change tenses and first person, along with shortening sentences and then reading through for clarity a second time

Reading the history of everything by an archaeologist and anthropologist; quite interesting about the origins of inequality

04/04/2022

Monday, April 4, 2022
4:34 PM

Is this the only way you are addressing resistance and or challenge. Need to tie in ideas of resistance

Reiteration

Re-articulation

Repetition of the dominant discourse

Dispersed Resistance:

Everyday resistance; pervasive use of disguise through concealment of the resister; resistance that is quiet, dispersed, disguised or otherwise seemingly invisible; tactics that exploited people use in order to both survive and undermine repressive domination;

Displayed as a form of resistance that sits alongside individually performed "extraordinary" or manifested forms of resistance; could be either subtle and everyday character or more glaring appearance;

Dispersed resistance may occur once; might inspire others to carry out similar practices; or social movement; It is when instances of dispersed resistance spread and inspire followers to imitate or innovate that such individual resistance might have cumulative and large-scale political effects.

Dispersed resistance may be glaring or hidden but carried out by a few people; Seems to be performed according to different scripts, with different aims and techniques depending on what form of power it is reacting against. Foucault uses resistance to bring to light power relations, locate their position, and find out their point of application and the methods used;

Counter-repressive resistance: individual or small scale resistance against repressive - sometimes **sovereign power**; a power that makes use of the law and law-like regulations; resistance against different forms of repressing power; aims at an improved livelihood and ways of negating repressive forces (vs discursive change of truth regimes)

Carried out in an individualistic and quiet way; becomes public when state cracks down; This resistance aims at an improved livelihood and ways of negating repressive forces rather than a discursive change of truth regimes; This resistance aims to address rules, practitioners of regulations, decision-making bodies

and authorities have legal force; to undermine or avoid vs meaning-making; establishes practice directed towards elite claims;

Productive resistance: resistance against discursive power producing societies, identities and practices; researchers in this subfield of resistance emphasize the less than tangible entities such as texts, signs, symbols, identity and language; focus on cultural processes, ways of life, subjectivity and shared meaning systems and understood from concepts of dominant discourses and resistance.

Power or discourse can be reversed; resistance is intertwined with power and has to use the same techniques as power, but harness power otherwise to produce other effects; thus through reiteration, rearticulation or repetition of the dominant discourse with a slightly different meaning; This kind of resistance, then, appears as the effect of power, as a part of power itself and reverse discourses are parasitic on the dominant discourse they contest;

Techniques of the self involve practices through which individuals inhabit subject positions and transform existing subjectivities; possible to use in norm-conformative (and neoliberal) project of self-development, and as an attempt by individuals to transform themselves otherwise, counter to existing dominant norms; care of self - > resistance to the subjectivity given by power relations

Resistance occurs within dominant discourses and systems, yet simultaneously acts against domination; resistance that attempts to be governed a little bit less or not quite the same way by employing techniques of counter conduct; somewhat other ways of being are carved out from the discursive material and subjectivities that are made available; resistance creates social institutions, communities, political subjectivity, and subjugated knowledge in ways that utilize and open up cracks and undermine domination, yet without achieving complete liberation

06/04/22

Wednesday, April 6, 2022
6:38 PM

Interesting to see the problem behind the policies.

The solution provided is medical information and treatment; BUT it is to ensure that the employee is able to be productive and thus taken from an economic lens.

The solution provided of medical treatment is not for the purpose of improving the health of employees, BUT so that they can be productive in the neoliberal workplace

21/04/22

Thursday, April 21, 2022
7:22 AM

Discussion:

Disability Policies limit benefits and DM, RTW intervention through all-or-nothing approach to benefits and the medical model of disability

Bring in an occupationally based approach to DM (as defined by Nielsen)

WPMH as defined in Baynton & Fournier - if this needs to be defined, need to put into introduction?