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# 1 | Social work and disability: old and new directions

Prior to 1970, help for disabled people and their families was really only available through the health service (medical social workers) or voluntary organizations such as the Invalid Children's Aid Association and the Spastics Society. A few local authority health departments set up professional social work services in the 1950s, staffed mainly by medical social workers, and in some cases by occupational therapists as well. Welfare departments in the pre-Seebohm Report days also offered services to disabled people, but as most did not employ trained social workers, little was done beyond material help and information-giving, while some provision was made for residential care. The Seebohm Report, local government reorganisation and the Chronically Sick and Disabled Persons Act, 1970 was supposed to change all that and usher in a new era. This led to services for disabled people being established as a social services responsibility, but as with many local authority provisions it varied from one part of the country to another. The community care reforms brought in by the National Health Service and Community Care Act, 1990 were intended to bring some level of equity to disability services through transforming the organization of the statutory social services, while the Children Act, 1989 brought in separate provisions for disabled children, but criticisms that services were still based on the wrong approach to disability persisted. More recently, the introduction of direct payments and an emphasis on service user involvement in the delivery of assistance have begun to address some of these criticisms, while the current proposals for the introduction of community care trusts may bring about significant changes in the location and structure of disability services. Finally, as the Disability Discrimination Act, 1995 begins to impact on services provided by local authorities, it is likely to affect the latter's ability to maintain a traditional professionalised approach to the delivery of care; that

is, one that places the expertise in the hands of the social worker rather than the service user. What this has meant as far as social work with disabled people is concerned will thus be a major theme of this book.

### **The role of social services departments**

The current role of social service departments emanate from the Seebohm Report, which recommended the development of services for disabled people. Based on Seebohm, the Local Authority Social Services Act, 1970 established social services departments, and its recommendations on disability were incorporated into an additional Act, the Chronically Sick and Disabled Persons Act, 1970. Unfortunately, not only was this Act passed at a time of organizational upheaval when there were also the competing demands of other client groups, notably children, who had also been the beneficiaries of recent legislation, it also suffered from being inadequately resourced through the ambiguity of the money order resolution that accompanied it as a private Member's bill (Topliss and Gould, 1981). The consequence of this was that while the expectations of disabled people were raised, the new generic departments were unable to provide adequate support services, either in terms of practical aid or emotional support (Knight and Warren, 1978; Shearer, 1981a; Topliss and Gould, 1981).

By the mid-1980s, social services were under pressure from two directions – first from disabled people who were dissatisfied with the lack of autonomy they could achieve through the design of personal care services (Shearer, 1984) and its inequitable distribution (Fiedler, 1988), and second, from the government, which was concerned about the spiralling costs of welfare services for adults (Audit Commission, 1986). The first of these resulted in the Disabled Persons (Services, Consultation and Representation) Act, 1986 which attempted to ensure a voice for disabled people in the assessment of their needs. While succeeding at the parliamentary stage, the provisions of this Act were quickly superseded by the government's own proposals in *Caring for People* (Department of Health, 1989) which sought to control expenditure through the introduction of a quasi-market into the social welfare sector. While this reinforced the role of local authorities as the arbiters of need, the disability movement continued to argue its case for greater

control by disabled people of their own personal assistance (Oliver and Zarb, 1992; Morris, 1993; Zarb and Nadash, 1994). One of the results of these studies and the case they argued was the Conservative government's Community Care (Direct Payments) Act, 1996 which allowed money to be given directly to clients.

Direct payments, and more specifically what they represent in terms of putting the users of social services in control, became a cornerstone of the 1997 Labour government's social care policies. They argued that social services were going to need direction if they were to serve adults better, and that, in particular, they need to

- seek to promote people's independence while treating them with dignity and respect at all times, and protecting their safety;
- provide services more consistently across the country; and
- make the system more centred on service users and their families, and as convenient and straightforward as possible for people to use.

(Department of Health, 1998, para. 2.4)

In *Modernising Social Services*, the Secretary of State for Health outlined what the government saw as the problems disabled people faced within the care system. First among these was that services were often designed to do things *to* people rather than to support them: 'the guiding principle of adult social services should be that they provide the support needed by someone to make the most of their capacity and potential' (Department of Health, 1998, para. 2.5). The Department of Health noted that, despite increases in funding for services, fewer people were receiving support because of the way that local authorities were focusing on people with higher levels of dependency. This they argued, 'increases the risk that they [people with less dependency] in turn become more likely to need much more complicated levels of support as their independence is compromised. That is good neither for the individual nor, ultimately, for the social services, the NHS or the taxpayer' (Department of Health, 1998, para. 2.6).

Finally, the Department of Health stated that many people were being forced to live in institutions by local authority policies designed to reduce the costs of care, and that this was not desirable. Despite this, between 1996 and 2002 the numbers of 'physically/sensorily disabled adults' under 65 years of age being supported by

local authorities in residential and nursing homes in England remained constant, while for other groups there were reductions, and the overall trend saw a fall of 17 per cent (Department of Health, 1996 and 2003). The government had promised to take action to reduce this use of institutional care, through

- better preventative services and a stronger focus on rehabilitation;
- an extension of direct payments schemes;
- better support for service users who are able to work;
- improved review and follow-up to take into account people's changing needs;
- improved support for people with mental health problems; and
- more support for carers.

(Department of Health, 1998, para. 2.11)

The extent to which social services for disabled people have developed in recent times can be seen by exploring current policies and contrasting them to Seebohm's recommendations. To some extent, the change in government thinking reflects changes of attitude towards disabled people in society at large.

Seebohm's first recommendation was that services needed to develop, and more recently, as we have noted, the government are concerned that there are too few services for less dependent people, and that too many disabled people are still being forced into institutions. This has been a persistent pattern of inconsistency. In 1978, one study noted that 'Despite the substantial development of services for handicapped people and the considerable increase of expenditure on these services . . . there were widespread indications . . . that even the most active departments could develop their services further' (Knight and Warren, 1978, p. 70).

Ten years later, Fiedler (1988) described the provision of social and housing services as a 'lottery' in that it would depend on which authority area a disabled person lived in as to whether they would receive the support needed to live independently. Although some authorities might have made much progress, this is certainly not the case everywhere. In 2004, Barnes *et al.* reported that 'Overall seven years after implementation, direct payments remain marginal as a support option for disabled people. Data so far reveals an inequitable access across the UK, as well as reiterating the divisions

between impairment groups, age and ethnicity' (Barnes *et al.*, 2004, p. 11).

In the opening statement of a national inspection of English councils, the Social Services Inspectorate stated that, although independent living had become a reality for a few younger disabled people, primarily through direct payments and other creative schemes, the majority were 'still being offered services in a fragmented way without any obvious consideration of whether they will promote independence' (Fruin, 2000, p. 1). The first two messages of this report were that

1. Most councils and their staff still have fully to absorb and carry through the independent living philosophy.
2. Direct payments schemes are taking off slowly with some councils and some staff still ambivalent. The success of these schemes and of direct payment users' individual benefits needs further publicity so that success can breed success.

(Fruin, 2000, p. 7)

Seebohm's second recommendation suggested that a reasonably accurate picture of the size and nature of the 'problem' should be ascertained, and counting the numbers of people affected by disability was built into the Chronically Sick and Disabled Persons Act as a legal requirement. While all local authorities had conducted their own surveys, the question of accuracy remains. Most of those surveys located only about 50 per cent of the people that the government's own survey (Harris, 1971) suggested there might be. This rapidly changing picture continued with the second government survey (Martin *et al.*, 1988), from which, for example, the numbers of disabled people using wheelchairs was estimated at 360,000, while less than ten years later a survey of Disablement Services Centres found that this figure was closer to 714,000 (College of Occupational Therapists, 1996). Clearly many of the surveys are now out of date and this affects the accuracy of what they are reporting.

It is obvious, therefore, that it is an extremely complex and time-consuming business to maintain an accurate picture of the needs of disabled people in a particular area. Some have questioned the allocation of resources in this way, arguing that it would be more productive to spend money on direct services rather than on counting heads or updating registers. However, Huntington and Sapey

(2003) suggest that collecting information on the needs of social service clients is tending to become the primary objective of many agencies rather than the provision of services. They argue that this is because of the increased importance of information, particularly influenced by new technologies. The government view technology and the availability of information as being important, and as contributing to an increase in the respect accorded to disabled people by social service agencies:

Developments such as direct payments, *greater access to information, particularly electronic information*, and a culture that emphasises human rights, will all change the relationship between services and people who use them. Staff will be working with people *who are informed and know* what they can expect. Users' expertise will be respected. Such empowerment can only lead to better outcomes. [emphasis added] (Department of Health, 2000, p. 6)

Regardless of whether information empowers people to receive services or acts as a replacement, what is clear is that the head-counting approach has failed. As will be argued later in this chapter, the 'problem' of disablement may be better accounted for by auditing access issues.

With Seebohm's third recommendation, the onus was placed on social services departments to provide a wide range of services, foremost among these being a social work service for disabled people and their families. Few, if any, departments would have claimed to have provided such a service, and since the community care changes of 1993 the focus has moved away from social work. Other services, such as residential and day care, are often criticized, not on grounds of the failure to provide, but rather in terms of what is provided is not what disabled people want. Forcing disabled people to live in institutions was one of the key problems recognized by the government (Department of Health, 1998) as they 'can lead to lower self-confidence and a decline in activity' (para. 2.7).

Yet other services, such as direct payments, and aids and adaptations that are wanted by disabled people, are often criticized on the grounds of the failure of departments to allocate adequate resources to them (Glasby and Littlechild, 2002) or to give them sufficient priority (Stainton, 2002). The criticisms of local authorities in this

respect also concern the standard of social work practice – the Social Services Inspectorate reports that

We saw examples across the inspected councils of good elements of the assessment and care management process but we also saw scope for improvement, particularly in the physical disability field. Many assessments were partial with an emphasis on deficiencies, lacking an holistic approach to the person being assessed. Where different assessors were involved with the same person, users often experienced serial and multiple assessments which were not integrated either from the user's perspective or on the case records. Most care plans moved too readily to becoming service plans, with a lack of specification of intended outcomes and with referrals mainly to existing block-purchased services with limited flexibility and tailoring to meet the needs of the individual. (Fruin, 2000, p. 4)

The Health and Social Care Act, 2001 introduced care trusts as a new model for the delivery of care. These will be formed by partnerships of local authorities and NHS trusts, and could become the vehicle for the delivery of disability services. If, or rather when, they come into being on a large scale it would effectively end the Seebohm recommendation that services are based in social services departments, but their success would need to be judged on the later modernisation goals of promoting and supporting independent living. Whether social workers will continue to have a key role, and if so exactly what that will be, may depend on their usefulness in achieving this goal – in organisations that are dominated by health concerns it may be important to have personnel who have different priorities.

Seebohm's fourth recommendation was for the development of services for disabled school leavers. Following the recommendations of the 1978 Warnock Report, this had been left to the careers service, with each education authority in England and Wales employing specialist careers officers for disabled people.

Ways of measuring unemployment change quite frequently, and the type of help available also changes, notably the New Deal schemes of the 1997 Labour government. Despite this, in 2004, the Department for Education and Skills' own survey of the main activities of 18-year-olds showed that disabled people were continuing

**Table 1.1** Main activities of 18-year-olds, 2004

	<i>Weighted sample</i>	<i>Higher education (%)</i>	<i>Full time job (%)</i>	<i>Out of work (%)</i>
Has a disability or health problem	328	14	18	18
Does not have a disability or health problem	7394	27	31	6

*Note:* Percentages do not add up to 100 as several other activities have been omitted.  
*Source:* Adapted from Department for Education and Skills, 2004, table B.

to fare less well than their non-disabled peers (see Table 1.1). Two significant activities are those entering higher education, where the percentage for disabled people is about half that for non-disabled people; and in full-time employment, where the percentage is about two-thirds. In terms of non-activity, disabled people were three times as likely to be unemployed.

The importance of employment is recognised by current government policy (Cabinet Office, 2005), as is the importance of welfare services in helping disabled people in this respect. The third national objective of *Modernising Social Services* is

To ensure that people of working age who have been assessed as requiring community care services, are provided with these services in ways which take account of and, as far as possible, maximise their and their carers' capacity to take up, remain in or return to employment.

However, the Social Services Inspectorate found progress to be poor (Griffiths, 2001), particularly for people with physical impairments. Local councils were criticised for failing to consider employment needs adequately and for having charging policies that discouraged disabled people from seeking employment. Although direct payments were seen as having potential in this respect, the Social Services Inspectorate found that schemes had either not been introduced or were not promoted.

For many years most social services departments were also reluctant to attempt to identify the non-vocational needs of disabled young people for fear of raising people's expectations, and regarding the increased demands that might be created. This led to the passing of Sections 5 and 6 of the Disabled Persons (Services, Consultation & Representation) Act in 1986 which introduced formal procedures by which social services departments were obliged to communicate with education departments in order to identify and assess the social needs of disabled school leavers. While the actual provision of services remains the subject of rationing, as for other social service clients, it has led to a much greater acceptance on the part of local authorities of their responsibilities, albeit with a high level of formalisation.

Seebohm also called for improved co-ordination between services and this is still a major objective of *Modernising Social Services* and of the Health and Social Care Act, 2001. However, in a review of Seebohm, Phelan stated unequivocally that this may never be achieved:

Effective co-ordination is as elusive as perpetual motion and if truly achieved verges on acquiring that very characteristic, but frequently social provisions are either organised without acknowledgement of it or administered within a scope which endeavours to eliminate the need for it. *In services for people with handicaps, where generally co-ordination is required more than anywhere else, paradoxically it is to be found the least.*

[emphasis added] (in Cypher, 1979, p. 56)

Phelan may well have been proved right by the recent history of services since the implementation of the NHS and Community Care Act, 1990. This Act made inter-agency co-ordination mandatory and the emphasis from the Department of Health changed to one of co-operation. A range of guidelines and circulars were issued advising and instructing social services, health and housing authorities on how to ensure they worked together effectively. Critics, including the Audit Commission, would argue, however, that far from breaking down the barriers to co-operation and co-ordination, the introduction of market principles has created more impermeable boundaries determined by budgetary priorities and responsibilities. The Audit Commission described these barriers as

being like a 'Berlin wall'. However, co-ordination and co-operation between agencies remains essential to the smooth and effective delivery of services.

The issue of training, which forms the basis of Seebohm's sixth recommendation, was taken up by a Working Party convened by the Central Council for Education and Training in Social Work, whose major finding was encapsulated in its title: *People with Handicaps Need Better Trained Workers* (CCETSW, 1974). Their recommendations were for improved training at in-service, basic and post-qualifying levels. The introduction of the special option on 'handicap' as part of CSS courses, and the considerable number of professionals from social services departments who took the Open University course entitled 'The Handicapped Person in the Community' improved matters a little, but both of these have been superseded by other developments. Following the introduction of the Diploma in Social Work (DipSW) in 1989 and the ending of the CSS and CQSW programmes, CCETSW encouraged universities to develop disability options and to recruit disabled students (Stevens, 1991). Despite pressure from within higher education for courses to be made accessible, Crawshaw (2002) reports that disabled people constitute between 4 per cent and 8.8 per cent of social work students, well below what might be expected in an occupation that has so much to do with disability. Her project at the University of York sought to challenge the 'us and them' divisions in social work, and argued that including disabled students means that social work would 'start to encompass the values of inclusivity it espouses' (p. 512).

The publication of *A Quality Strategy for Social Care* (Department of Health, 2000) and *Requirements for Social Work Training* (Department of Health, 2002) emphasised the need for social workers to be skilled in working in partnership with service users. This has become one of the specific points that the General Social Care Council (GSCC) monitors when accrediting universities to teach social work and when approving their degrees. The Department of Health also made available funds to help universities pay service users to be involved in social work education, in the hope that they might bring disabled people into the classroom as teachers and develop their skills as trainers. This respect for the expertise of disabled people does reflect a considerable shift from the Seebohm approach, which would have seen social workers as having the expertise.

Seebohm's final recommendation was for closer co-operation between the statutory and voluntary sectors. Traditionally, the voluntary sector provision for disabled people extended from residential and day-care services to providing individual volunteers for gardening, driving people to appointments and so on. Hatch, in his study of voluntary organisations in three towns, found

At the local level most of the organisations for the handi-capped worked quite closely with the statutory services. Where they did not do so it seemed in the three towns more a result of statutory neglect than antagonism on the part of the voluntary organisation. Within this kind of relationship the voluntary organisations were able to communicate needs, but seldom did they openly challenge the adequacy of existing provision by taking up an active pressure-group role. (Hatch, 1980, p. 105)

This uncritical co-operation, which has been formalised through purchasing contracts since 1993, has been criticized extensively by organisations made up of disabled people. These groups of disabled people have consistently challenged the structures within which welfare has been provided (see Campbell and Oliver (1996) for a full account of their development). Organizations of disabled people have achieved notable success in campaigning for and demonstrating the advantages of direct payments, and for the involvement of service users in supporting people using direct payments. This support role was clear within Oliver and Zarb's (1992) study of the Greenwich Personal Assistance Scheme. Hasler *et al.* (2000), in their review of the development of arrangements for independent living, emphasise that local authorities that are implementing direct payment schemes should look to collaborating with disabled people's organisations, which have considerable experience in providing such support.

The Social Services Inspectorate (2000) have also recommended such collaborative arrangements as being essential to the implementation of direct payments, and this is reflected in their standards for inspections of local authorities (Social Services Inspectorate, 1999). Some innovative work in this area was carried out by the King's Fund Centre in their Living Options project. Fiedler (1991) made the point that the involvement of service users within social services could range from information, through

consultation and partnership to delegated control. She viewed these as stages in a process that would, and should, result in delegated control rather than being a choice of different models of user involvement. Later the *Shaping Our Lives* project was established as a user-controlled network, with the main aim of ‘supporting the development of local user involvement that aims to deliver better outcomes for service users’ ([www.shapingourlives.org.uk](http://www.shapingourlives.org.uk)).

In this way, the agenda has moved on considerably since Seebohm’s report, with the emphasis being on partnership with service users and a recognition of the value of the support that organisations of disabled people can provide, as opposed to the more traditional services provided by non-user-controlled agencies.

Any attempts to assess progress accurately since Seebohm are obviously difficult, but in the light of what has been said it is not unreasonable to conclude that the modernisation of social services will require a substantial change in the attitudes and practice of social workers. It is in this area of social work services specifically that the least progress has been made, and in the rest of this chapter some of the reasons why this should be so will be considered before going on to outline some of the ways in which social work intervention with disabled people can be made more positive.

### **Social work services for disabled people**

The role of social workers may be affected by organizational developments, but in essence has changed little since 1970. Although in theory their role has been envisaged as being quite broad, including the provision of personal social work help to individuals and families, the assessment of needs, the provision of support and rehabilitation, support and training of social care staff, and co-ordination of care packages (CCETSW, 1974; Stevens, 1991), in practice social workers have had a much more limited role.

There have been a number of studies that have discussed social work in relation to disabled people – but few have been complimentary to social work. Historically, for example, Parsloe and Stevenson (1978) found that the level and extent of social work intervention with disabled people was relatively low, and that occupational therapists or social work assistants provided the most input to disabled people and their families. Goldberg and Warburton (1979) found that social work intervention both lacked depth and

fares badly in comparison with work with other client groups. At the time the Barclay Committee reported, these and other studies confirmed that disabled people had less access to skilled social work support, for, as they noted, ‘unqualified, inexperienced or assistant social workers carry proportionately more cases of physically handicapped and elderly people’ (Barclay Committee, 1982, p. 11).

Social workers also failed to recognise the potential of working with disabled people and ‘the preservation of the status quo was all the social workers hoped for’ (Goldberg and Warburton, 1979, p. 93). Another study (Phillips and Glendinning, 1981) found that social work intervention could even be positively harmful: ‘some people had even been given inaccurate information from social workers which had deterred them from making applications for benefits and caused subsequent financial losses’ (p. 43).

Burgess (1982) wrote of a case where, despite regular social work intervention, the disabled client had lost more than £4,000 in unclaimed benefit in the previous few years. Despite the attention that has been brought to this lack of information, Grewal *et al.* (2002, p. 173), in a study involving nearly a thousand disabled adults, conclude that ‘a perceived lack of readily available information was frequently cited as an important contributor to the social exclusion that some people described’. Priestley (2004) criticises the core role of social work as being structured to enforce dependency:

The practice of care assessment and management is not simply a technical ‘gate-keeping’ mechanism – it defines disabled people’s needs in a very particular way. Value-laden purchasing decisions can perpetuate the myth of ‘care’ over independent living by focusing resources on personal care and limited domestic chores at the expense of support for social integration. Thus, care assessments all too frequently consolidate the social segregation of disabled people in their own homes, rather than challenging their enforced dependency. (p. 259)

While many social services departments and voluntary sector agencies undoubtedly established better services for disabled people during the 1980s, these were struggling to survive by the 1990s. The development of advisory (d’Aboville, 1991) or advocacy (Middleton, 1992) services that have been regarded positively by disabled people and their families came under threat through the

focus on quantifiable outcomes that have been popularised in the new public-sector management. A particular result of the managerialisation of welfare during the 1980s and 1990s was the conversion of many social work managers to the creed of quality assurance. This doctrine claims that it is of no importance as to who delivers or arranges a service so long as it is provided, but this contradicts much of the evidence from consumers of welfare (Howe, 1987; Morris, 1993; Willis, 1995) that the way in which social workers undertake their duties is important. Not only does this doctrine ignore the wisdom of experience of the Poor Laws – that it was necessary for the administrators of welfare to ‘humanise the relationship between the poor and authority’ (Albert Evans MP, quoted in Silburn, 1983) if they were to overcome the stigma attached to receiving assistance from the state; it also contradicts evidence from practice. For example, Dawson (2000) found that the take-up of direct payments was affected most by the attitude of social workers, a clear indication of both the positive and negative effects that approaches to professional practice can have on the lives of disabled people.

Furthermore, the failure of social workers to develop an adequate theoretical and practice base for their interventions has led to criticisms, notably by disabled people themselves, who have accused social workers of ignorance about disabling conditions, benefits and rights, failing to recognise the need for practical assistance as well as verbal advice, and to involve disabled people in the training process. They have also expressed resentment at being treated on a less than equal basis in the professional/client relationship (Finkelstein, 1991). In addition, while disabled people have therefore been critical of social workers, social workers themselves have often been reluctant to throw themselves wholeheartedly into work with this particular group. As a measure of social workers’ lack of interest, Sapey (2004) reported that in a review of papers on disability relevant to social work, only one in eight were published in social work journals, while more than half were within the disability studies field, led by disabled people. Certainly there are a number of reasons for this, which may include the following. First, low priority is given to work with this group and hence there are restricted career prospects within the statutory social services for anyone wishing to specialise in this type of work. Second, there is a lack of understanding of the potential of working with this group, because, as one writer put it:

Many people believe that work in the field of physical disability must be depressing because they have a vision of custodial care and of crippled lives filled with sadness and lost dreams. In actuality, rehabilitation of the physically disabled is especially rewarding because of the potential that exists in human beings in the face of stress, a potential that has seriously been underestimated.  
(Trieschmann, 1980, p. xi)

Third, as has already been said, inappropriate teaching about disability on some training courses may mean that workers feel inadequate or incompetent when working with disabled clients. Finally, personal fears about impairment may mean that workers may be reluctant to get involved in what they perceive to be the personal and social consequences of adjusting to a human tragedy or disaster. But the major criticism is that social workers, like all other professionals, have largely operated with inappropriate models or theories of disability, and it is in a sense perhaps fortunate that social work intervention has been so limited. There have, of course, been several attempts to change this, both from within and outside the profession (Oliver 1983, 1991; Holdsworth, 1991; Stevens, 1991; Middleton, 1992, 1995; Morris, 1993, 1997a; Swain *et al.*, 1993; Thompson, 1993; Cavet, 1999; Oliver and Sapey, 1999; Moore *et al.*, 2000; Read and Clements, 2001; Harris, 2004), but there is little evidence that employers of social workers have made significant changes in the environments in which they practise. As Holdsworth pointed out:

The practice of empowerment social work can thus be seen to entail a radical shift in attitudes on the part of the social worker, and ultimately on the part of Social Services Departments and society as a whole, if continual conflict between individual social worker and employing agency is to be avoided. However, as societal and Social Services Department views are unlikely to change sufficiently rapidly, the individual social worker is likely to experience at least periodic conflict with her employing agency as she aligns herself with her client in an attempt to fulfil a jointly agreed-upon service need.  
(Holdsworth, 1991, p. 10)

Before going on to consider an appropriate model of social work intervention, it is necessary to discuss why the current model is inappropriate. For this purpose the inadequate model will be referred to as the 'individual model' of disability.

### **The individual model of disability**

The individual model of disability sees the problems that disabled people experience as being a direct consequence of their impairment. The major task of the professional is therefore to adjust the individual to the particular disabling condition. There are two aspects of this: first, there is physical adjustment through rehabilitation programmes designed to return the individual to as near normal a state as possible; and second, psychological adjustment that helps the individual to come to terms with his or her physical limitations. It is not just that social work had accepted the dominant, individual model of disability that is deeply embedded in social consciousness generally, but that the struggle for professional status and acceptance has also been involved: 'In a search for professional status, social work has emphasised a medical, psychotherapeutic, individualised model of work because that seemed the best way of asserting its expertise and professionalism' (Wilding, 1982, p. 97). It is possible to be critical of both these aspects of adjustment, and it is the latter that will be focused upon as it is of most relevance to social work, though there have been criticisms of the former also (Brechin and Liddiard, 1981; Barnes, 1991).

Starting from the assumption that something happens to the mind as well as to the body when a person becomes disabled, a number of psychological mechanisms of adjustment have been identified, or more appropriately borrowed from other areas such as death and dying. Disabled individuals are assumed to have undergone a significant loss, and as a result depression may set in. In order to come to terms with this loss, a process of grieving or mourning will have to be worked through, in similar manner to those who must mourn or grieve for the loss of loved ones. Only when such processes have been worked through can individuals cope with death or disability. As one Kleinian social work writer put it:

Illness and accidents at any age may confront us with slow or sudden loss of abilities. Denial of the limitations imposed

can only lead to a superficial adjustment, which hides underlying persecution and depression. It is only when the work of mourning has been done and the anger, despair, and depression are eventually mitigated by love and courage, that the individual can go forward. If anger and despair predominate permanently, the individual regresses to an earlier stage of development, becoming self-centred, self-pitying, with a chip on his shoulder and begrudging others their freedom, or infinitely demanding of their time and attention. If the loss can be admitted, mourned and accepted with courageous resignation, a heightened appreciation of the remaining gifts and opportunities can lead to development in a different direction. (Salzberger-Wittenberg, 1970, p. 106)

These mechanisms are often seen as a series of stages or steps which have to be worked through. A study by social workers (Weller and Miller, 1977) in New York University Hospital identified a four-stage process by which newly disabled paraplegics come to terms with their disability:

**Shock:** The immediate reaction to the physical and psychic assault of spinal-cord injury, often characterised by weeping, hysteria, and occasionally psychosis with hallucinations.

**Denial:** A refusal to accept that complete recovery will not take place.

**Anger:** Often projected towards those physically active around them, who serve as constant reminders of what has been lost.

**Depression:** A realistic and most appropriate response to a condition of severe and permanent disability, and a necessary stage if adjustment, rehabilitation and integration are to be achieved.

Thus the social work task is to help disabled individuals through these adjustment stages.

Albrecht (1976) characterised this and various other schemes as developmental models and argued that they all, at least partially, assume that:

- (a) an individual must move sequentially through all these stages to become fully socialised;
- (b) there is only one path through the stages;
- (c) an individual can be placed clearly in one stage by operational criteria;

- (d) there is an acceptable time-frame for each stage and the entire process;
- (e) movement through the system is one way, that is, the system is recursive.

It is not just in the case of spinal-cord injury that such models are considered appropriate; there are certainly similar ideas in the area, for example, of blindness. According to Carroll (1961, p. 11), 'loss of sight is dying. When in the full current of sighted life blindness comes on a man, it is the end, the death, of that sighted life'. In order to come to terms with this death, Fitzgerald (1970) identified four distinct phases in the typical reaction to the onset of blindness: disbelief, protest, depression and recovery.

There are a number of general criticisms that can be levelled at individualistic theories or explanations. First, these theories implicitly picture the individual as determined by the things that happen to him or her – and the adjustment to disability can only be achieved by experiencing a number of these psychological mechanisms or by working through a number of fixed stages. Second, adjustment is seen to be largely an individual phenomenon, a problem for the disabled person, and as a consequence the family context and the wider social situation are neglected. Finally, such explanations fail to accord with the personal experiences of many disabled people who may not grieve, mourn or pass through a series of adjustment stages. As Clark states; 'The loss of sight need not and usually does not touch the core of a man's intellect and emotional being. What has changed is his relationship with the external world, a relationship with which he had grown so familiar that he scarcely thought of it' (Clark, 1969, pp. 11–12).

However, it is not just in the field of disability that the 'stages' approach has been rejected. Thompson (2002a) draws attention to developments in the sociology of loss and grief that are a reaction to the over-prescriptive nature of psychological explanations of how people respond to death and dying. The dual process model is an attempt to understand why people do not follow these stages, but instead move between a loss and a restoration orientation. Rather than being a process that results in acceptance, the dual process model describes the way that people fluctuate in the way they deal with loss. Thompson argues that the advantages of this approach are that it 'moves us away from the narrow, psychologistic

approach which presents grieving as a (largely biologically-based) natural process and alerts us to the complex web of psychological, cultural and socio-political factors which interact to make loss experiences far more complex than traditional approaches would have us believe' (Thompson, 2002a, p. 7).

Similarly, the meaning reconstruction approach of Neimeyer and Anderson (2002) also rejects the stages model. This model argues that there are three important aspects to reconstructing meaning after a loss: sense making, benefit finding and identity reconstruction. The ways in which people reconstruct meaning varies according to their individual psychological dispositions, spiritual beliefs and social support systems rather than through some predetermined psychological process.

Despite these criticisms, it would be true to say that the stages approach has made up the dominant, individual model of disability and this in itself needs to be explained. A major factor in this is that these theories are in accord with 'the psychological imagination', in that theorists have imagined what it would be like to become disabled, assumed that it would be a tragedy and hence decided that such an occurrence would require difficult psychological mechanisms of adjustment. Wilson (2003) for example, draws on Kleinian psychoanalysis to argue that we can distinguish certain commonalities amongst people with congenital impairments. In discussing one man who has been troubled by his difficulty with women not finding him sexually attractive, she concludes that

Unlike non-disabled children, who try to deny that their existence is due to their parents' lovemaking, children born with an impairment feel connected to that sexual act. Their hatred of parental sexuality is often displaced onto themselves or others. Society's negative and often denigrating reaction to disability contributes to their perception that they must be the result of bad intercourse.  
(p. 100)

There is no foundation for this assertion; rather it is Wilson's application of a particular way of thinking in which she chooses to pathologise disabled people for the responses of others. The psychological imagination is clearly not an appropriate starting-point for such theorising or research – it is surely a value judgement

to assume that disability is a tragedy rather than a phenomenon that might be explained in a number of ways.

Another factor is that these explanations, being individualistic, are thereby politically convenient. When a disabled person fails to internalise the rehabilitation goals set by the professionals, or persistently pesters his or her local social services department, he or she can be characterised as having problems in adjusting to the disability. This conveniently leaves the existing social world unchallenged; the goals of the rehabilitator remain unquestioned and the failure of the welfare department to provide the right assistance can be ignored.

While these and other factors may explain the adherence to these psychological theories, they do not explain why the theories have been validated empirically by a number of studies (Berger, 1988). In fact, these theories may become self-fulfilling in at least two ways. At a methodological level, having conditioned themselves in the sense that they posit adjustment to disability as a problem, researchers then ask questions relevant to that problem and get answers that are then presented as findings – valid social facts. Prior to the criticisms of this model by disabled people there had been few, if any, studies which started out from the assumption that disability was not an individual problem. The following quote illustrates the point nicely:

Reflection on the many problems to which the cord injured person must make an adjustment impresses one with the gravity of the psychological processes which occur following cord injury.

Such an individual is confronted with grieving over his loss, coping with pain and phantom sensations, alternations in sexual functioning, loss of bladder and bowel control, the frustrations of immobilisation, loss of vocational goals and earning capacity, feelings of uselessness, role reversals in the family and the attendant loss of self-esteem and the social stigma of being ‘different’ in the public eye. *It is an amazing tribute to the flexibility and magnificence of the human spirit that so many people whose lives are thus devastated survive and function at the level of physical and social independence which most cord injured people achieve.*

[emphasis added] (Ibbotson, 1975, p. 5)

This quote accurately reflects the process of 'sanctification' of disabled people that is deeply embedded in the social consciousness and reinforced through stereotyped media presentations.

There is a polar opposite of this image which presents disability as a tragedy and personal disaster. As Shearer suggests:

The 'norm' demands that people whose disabilities are obvious and severe must be at least 'sad' and even 'tragic'. And if that defence breaks down in the face of individual reality, it is ready with its own flip-side. The reaction of people who break out of the mould becomes: 'Aren't they wonderful?' (Shearer, 1981b, p. 21)

In view of these images it is understandable that social workers are reluctant to get involved, as the scope of professional intervention with super-heroes or tragic victims must appear to be somewhat limited. However, the basic point remains: instead of questioning social reality with regard to disability, researchers simply proceed on the basis of taken-for-granted everyday meanings. But as so many disabled people are able to function at a reasonable level, it is surely more logical to assume that this is a normal, everyday reaction. To put the matter simply, adjustment may be normal and not a problem at all.

There is a second way in which these theories may become self-fulfilling, in that they may in fact create the reality they purport to explain. In the case of mental illness, it has been shown that psychiatrists impose their own definitions of the reality of particular problems on their patients. Similarly in the study of criminal behaviour, it has been shown that criminals will often verbalise theoretical explanations picked up in sessions with psychiatrists, psychologists and welfare workers as excuses for their behaviour even in compulsive crimes such as pyromania, kleptomania and child molestation. With regard to disability, many disabled people will have contact with the theories described above, not through meeting academic psychologists or participating in research projects, but through everyday contact with professional workers who are also internalising these theories.

Finkelstein has argued that the use of such concepts is nothing less than the imposition of standards of able-bodied normality on the meaning of disability for disabled individuals, engendered partly by the 'helper/helped' relationship:

The attitude that a disabled person has ‘suffered’ a personal loss is a value judgment based upon an unspoken acceptance of the standard being able-bodied normalcy. But attributing loss to disabled people is not just the whim of certain helpers. The existence of helpers/helped builds into this relationship normative assumptions. ‘If they had not lost something they would not need help’ goes the logic ‘and since it is us, the representatives of society doing the help, it is this society which sets the norms for the problem solutions’.  
(Finkelstein, 1980, p. 17)

What is being suggested is that the psychological mechanisms and processes that research has identified and described are themselves the product of that research activity, both as a result of its methodological predispositions and the spread of this knowledge to professionals, who are then able to impose this definition of reality upon their clients. This is captured by Trieschmann, who asks:

Have professionals been describing phenomena that do not exist? Have professionals in clinical interactions placed disabled persons in a ‘Catch 22’ position? If you have a disability, you must have psychological problems: if you state you have no psychological problems, then this is denial and that is a psychological problem. And because this is so, have psychologists, psychiatrists, social workers and rehabilitation counsellors lost credibility with other rehabilitation personnel and with persons who have spinal cord injury, and rightly so?  
(Trieschmann, 1980, p. 47)

And it is not just a matter of losing faith, but, as she points out, disabled people ‘have felt victimised by professionals who write articles about the reactions to spinal cord injury that are based more on theory than fact’ (Trieschmann, 1980, p. xii).

The use by social work of psychological and physiological explanations of disability has been reinforced by the use of technology, a focus on quantifiable outcomes and the behaviourist nature of much evidence-based practice. The process of compartmentalising and coding ‘abnormality’ that is derived from the individual model is administratively convenient. The introduction of new technology with an algorithmic basis of analysis leads naturally to the selection of explanations that permit some quantifiable

form of linking behaviour and need. Rather than seeking to understand the nature of the relationship between impairment and disability, the instrumentally-driven bureaucratic processes that prevail (Blaug, 1995) seek an analysis that is compatible with the technology, and therefore it is of little surprise that the use of such classification systems are promoted as the way forward for social welfare (Ypren, 1996).

Despite the long-standing criticisms, it is clear that the individual model remains the dominant one with regard to disability and it has perhaps taken on the attributes of what Kuhn (1962) has called a 'paradigm' – that is, a body of knowledge to which all those working in the field adhere. However, the same writer has shown that paradigms are sometimes replaced or overthrown by 'revolution', and this revolutionary process is often sparked by one or two criticisms of the existing paradigm. Only then can a new paradigm develop to replace the old. Having provided one such criticism, it is now worth considering what a new paradigm – a 'social model' of disability – might look like.

#### **A social model of disability**

This new paradigm involves nothing more or less fundamental than a switch away from focusing on the physical limitations of particular individuals to the way the physical and social environments impose limitations upon certain groups or categories of people. Shearer captured the need for this change in paradigm in her criticism of the International Year of Disabled People:

The first official aim of the International Year of Disabled People in 1981 was 'helping disabled people in their physical and psychological adjustment to society'. The real question is a different one. How far is society willing to adjust its patterns and expectations to include its members who have disabilities, and to remove the handicaps that are now imposed on their inevitable limitations?  
(Shearer, 1981b, p. 10)

Adjustment within the social model, then, is a problem for society, not for disabled individuals.

For some, however, it is not just a matter of society's willingness to adjust its patterns and expectations, but one of removing the

social oppression that stems from this failure to adjust. The Union of Physically Impaired Against Segregation (UPIAS) stated:

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called 'disability', of people with such impairment. Thus we define impairment as lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body; and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them in the mainstream of social activities. Physical disability is therefore a particular form of social oppression. (UPIAS, 1976, pp. 3–4)

While both Shearer and UPIAS are advocating a social model of disability, there are differences in their views that need to be acknowledged. Shearer is asking society (that is, able-bodied society) to remove the disabilities imposed on impaired individuals, whereas UPIAS argue that such disabilities will only be removed by disabled people themselves who engage in active 'struggles'. Thus the former sees the reduction or removal of disability as something which may be given, whereas the latter sees it as having to be fought for. There are obviously different implications for professional practice stemming from these views, which can be encapsulated in asking professionals whether they wish to work for disabled people or with them.

This social model of disability, like all paradigms, has a fundamental effect on society's world view and, within that, the way particular problems are seen. If the problem of housing for disabled people is taken as an example, the individual model focuses on the problems that disabled people encounter in terms of getting in and out, bathing, access to the kitchen, the bedroom, and so on. In short, the approach focuses on the functional limitations of individuals in attempting to use their own environment. The social model, however, sees disability as being created by the way housing is unsuited to the needs of particular individuals. Thus we have 'housing disability'. A housing research

project in Rochdale (Finlay, 1978) attempted to operationalise this concept by taking as given the 'reduced performance capabilities' of particular individuals and measuring instead the restrictions that unsuitable housing environments placed upon the individuals concerned. The implications of this approach for professionals involves a switch in emphasis away from the provision of personal aids (most of which are not used in any case) and remedial therapy and a move towards adapting environments so that they do not unduly restrict people with functional limitations.

The longer-term policy implications of this approach centre on

whether the policies most suited to their needs should adopt a preventative approach, in the form of more suitable housing provided in the community, or a remedial approach in the form of paramedical support provided either in the home or special institutions by people whose very intervention, if made unnecessarily, is by itself a disabling factor in the lives of physically handicapped people.

(Finlay, 1978, p. 15)

Applying a social model approach to housing is not just about physical access. In the case of disabled children it is also about issues such as play space, safety, location and housing quality (Beresford and Oldman, 2002); it is about design that enables families with a disabled child to live together rather than resorting to institutional solutions such as respite care. In the case of visually impaired children, environmental factors become important and those living in more deprived areas find it more difficult to gain confidence and independence (Allen *et al.*, 2002).

The same perspective can provide important insights in other areas: the well-known problems of finding out about benefit entitlements are examples of 'information disability' (Davis and Woodward, 1981). They argue that

Information disability is a specific form of social oppression. In practice, it results in the disadvantage or restriction of activity caused not by the impairment of the individual – but by the way in our society we present, or withhold, information and prevent opportunity for full participation in the mainstream of social life.

(Davis and Woodward, 1981)

When applied to the world of work, the social model of disability provides equally valuable insights:

The world of work (buildings, plant, machinery, processes and jobs, practices, rules, even social hierarchies) is geared to able-bodied people, with the objective of maximising profits. The growth of large-scale industry has isolated and excluded disabled people from the processes of production, in a society which is work centred.  
(Swain, 1981, pp. 11–12)

This is crucial in late capitalist society, where individuals are still judged on what they do and appropriate social status is accorded. Hence it is not difficult to see that the dominant social perception of disabled people as ‘dependent’ stems not from their inability to work because of their physical limitations, but because of the way in which work is organised in modern industrial society.

According to Finkelstein (1980), this social model of disability may be applied most appropriately to physical impairments, but can also take in sensory impairments. For example, Deaf people may be disabled by the increasing use of the telephone, which restricts people who can communicate perfectly adequately at a face-to-face level, or meetings may be held in badly-lit rooms, so that they cannot see other participants adequately and follow the movements of their lips. Harris (1995) suggests that Deaf people who use British Sign Language (BSL) suffer a disadvantage because of linguistic isolation in employment situations where the majority of workers are hearing. In fact, pressure is exerted on Deaf workers to behave as much like hearing workers as possible – in effect, to ‘deny’ and make invisible their deafness. She argues that many Deaf people work in situations where there is a complete lack of meaningful communication between themselves and colleagues. The disadvantages suffered by Deaf people stem from a lack of tolerance and respect for linguistic difference by management and co-workers, and as such become individualised as a problem for Deaf workers to solve, rather than for hearing people to view as a challenge (Harris, 1997). However, Harris suggests that such a change in attitudes by hearing people and a willingness to learn BSL could radically alter the pattern of disadvantage and provide an empowering environment for Deaf people.

Sayce (2000) and Beresford (2004) both argue that the social model

of disability has relevance for people with mental distress. Sayce describes a disability-inclusion model in which she calls for a two-pronged attack on the causes of stigma and social exclusion; first, strong anti-discrimination legislation; and second, the assertion of a positive identity by saying 'no to shame'. Both she and Beresford also recognise that there may be tensions, not least because the social model accept the notion of impairment, whereas many people labelled as 'mentally ill' would not see their 'distress' as an impairment.

Similarly, learning difficulties can be seen as less the problem of the intellectual impairment of certain individuals, but more related to general expectations about levels of social competence (Marks, 1999). As Dexter wrote:

In our society, mental defect is even more likely to create a serious problem than it is in most societies because we make demonstration of formal skill at coordinating meanings (reading, writing and arithmetic) a requirement for initiation into adult social status, although such skills are not necessarily related to the capacity for effective survival or economic contribution.

(in Boswell and Wingrove, 1974, p. 294)

Since its development there have been criticisms of the social model. Morris (1991) raised the concern that the social model might be oppressive if it is imposed in such a way as to deny the experience of individuals. Drawing on feminist criticisms of male theorising, she suggests that the danger lies in attempting to compartmentalize the personal feelings and experiences of people rather than grounding the political analysis in them. Crow (1996) supports this position and calls for the inclusion of impairment in the theorising of the social model:

We need to take a fresh look at the social model of disability and learn to integrate all its complexities. It is critical that we recognise the ways in which disability and impairment work together. The social model has never suggested that disability represents the total explanation or that impairment doesn't count – that has simply been the impression we have given by keeping our experiences of impairment private and failing to incorporate them into our public political analysis. (Crow, 1996, p. 66)

Some disabled people do experience the onset of impairment as a personal tragedy, which, while not invalidating the argument that they are being excluded from a range of activities by a disabling environment, does mean it would be inappropriate to deny that impairment can be experienced in this way. Such reactions may themselves be caused by the extent to which the norms and values attached to the individual model have embedded themselves within our psyche. Drawing on Thomas's (1999) work about the psycho-emotional dimensions of disablism, Reeve (2002) discusses the way in which oppression becomes internalised for disabled people, not as a result of an individual psychological deficiency, but as a consequence of their treatment within a disabling society. The values of the social model have been shown to be effective in combating these effects. Tate *et al.* (1992) reported on a study which showed that people with spinal injuries who were put on an 'independent living program' at the time of their acute rehabilitation were able to adjust to their new circumstances with fewer negative psychological effects than those who received a more traditional, medically orientated service. Furthermore, many individual disabled people have borne, and continue to bear testament to the value of the social model to them personally:

My life has two phases: before the social model of disability, and after it. Discovering this way of thinking about my experiences was the proverbial raft in stormy seas. It gave me an understanding of my life, shared with thousands, even millions, of other people around the world, and I clung to it. (Crow, 1996, p. 56)

Some researchers have attempted to incorporate a model of impairment that is consistent with the social model of disability. Creek *et al.* (1987), in their study of the social implications of spinal injury, used the theoretical approach of viewing impairment as a significant life event. As with other life events, individual reactions are related to a range of social and personal factors. This interactionist approach takes into consideration the prior experience of individuals, and acknowledges the impact this will have on the adjustment they make to change, while also being consistent with the social model of disability.

A further criticism of the social model was raised by Stuart (1994), who suggests that the social model has tended to be an

exclusive analysis that had failed to acknowledge the multiple oppressions of black disabled people. He explains:

The oppression of medicalisation and the potential for empowerment of the social model is as relevant to black disabled people as it is to any other disabled people. The legitimate point of view of this group should be perceived as, perhaps, broadening our understanding of the disabling process and the methods of achieving empowerment. It should also be acknowledged that these people might not accept that the social model, as it is currently theorised, will provide the intended liberation. To do so, it is important to acknowledge that disability itself has been racialised. In other words, the perception of disability differs depending upon the colour of an individual's skin or his or her ethnic identity.

(Stuart, 1995, p. 372)

This experience of black disabled people suggests that racism is operating within the disability movement just as it is operating within other institutions in Britain and that organisations of disabled people are not in some way exempt or immune from acting oppressively towards black people. Ahmad (2000) argues that the social model may 'seem over-westernised' as it has come from a political movement that is historically and culturally specific. Furthermore, given the ways in which black disabled people experience the provision of social work services as racist (Begum *et al.*, 1994), it is clearly necessary for the social model of disability to incorporate an understanding of these differing perceptions of disability if it is to provide an analysis that is inclusive.

As we explain further in Chapter 2, a key reason for understanding disability within a social model and rejecting individual explanations is that historically, experiences of disablement have been located culturally in responses to impairment (Gleeson, 1999; Borsay, 2005). Furthermore, the social model of disability is just that, a model, not a social theory. Therefore it has the capacity to be used to understand a range of different experiences rather than necessarily dictating to disabled people what their experiences should be; those experiences will undoubtedly be culturally located and reflect differences of class, race, gender and so on.

The overriding importance of this social model of disability is

that it no longer sees disabled people as having something wrong with them – it rejects the individual pathology model. Hence, when disabled people are no longer able to perform certain tasks, the reasons are seen as the poor design of buildings, unrealistic expectations of others, the organisation of production, or an unsuitable housing environment. This inability therefore does not stem from deficiencies in the disabled individual. As Finkelstein (1980, p. 25) points out, 'The shift in focus from the disabled person to the environment implies a shift in the practical orientation of workers in the field.' What does this mean for social work? It is this question that will now be considered briefly.

### **The social model and its implications for social work**

The social work profession has failed to give sustained consideration to physical disability, in terms either of theory or practice. However, as was suggested earlier, it is perhaps fortunate that there has been this lack of sustained interest, as social work has adopted the wrong model of disability. Outlining a social model of disability before going on to discuss some of its implications for social work practice goes against the current conventional wisdom, which suggests that theory should be practice-based rather than the other way round. Nevertheless, to rely on practice to inform theory when practitioners may have already internalised an inappropriate model is to invite disaster, as it would merely result in reinforcement of the individual model of disability at a theoretical level. Therefore, an attempt has been made to lay the theoretical base before considering some of the practice implications. This discussion will inevitably be brief, because it is for practitioners themselves to work out, in conjunction with their disabled clients, the full implications, and not for academics to extract practice blueprints from their theories.

If consideration is first given to the three main traditional social work approaches (casework, group work and community work), it is possible to make a number of statements relevant to practice. For example, the switch from an individual to a social model of disability does not signify the death of casework. Rather, it sees casework as one of a range of options for skilled intervention. It does not deny that some people may grieve or mourn for their lost able body, but suggests that such a view should not dominate the social

worker's assessment of what the problem may be. Thus grief work or bereavement counselling may be appropriate in some instances, but not in all or even in most. Some disabled people, particularly those with progressive diseases, may need long-term support of the kind that only a casework relationship can provide, and indeed the whole family may become the target for casework intervention (see Lenny, 1993; Oliver, 1995; Reeve, 2000, 2004; Lago and Smith, 2003, for a discussion of counselling). Equally, a casework approach may be used to provide support to disabled people while they are learning to use direct payments effectively.

Similarly, groupwork need not focus solely on the need to create a therapeutic environment in which individuals or families can come to terms with disability. Groups can also be used to pool information on particular benefits, knowledge on where and how to get particular services, and even on a self-help basis to give individuals the confidence to assert that their disability does not stem from their impairments, but from the way society often excludes them from everyday life. In addition the group can be used as the major means of giving disabled people back the responsibility for their own lives, as is described in a discussion on residential care: 'meetings in the small residential groups were a forum for staff and residents to plan their activities and to determine priorities. They gave the opportunity for residents to take responsibility for themselves and also for the staff to do "social work" ' (Dartington *et al.*, 1981, pp. 52–3).

The potential for intervention using community work methods is also exciting. There are many local access groups that focus on the way the physical environment disables people, and numerous access reports and guides have been produced. Sometimes community workers have organised 'forum' meetings of all organisations of, and for, disabled people in a particular locality and these have proved useful in confronting local authorities about cut-backs, and in ensuring that the needs of disabled people are taken into account in pedestrianisation schemes and so on. Marian Barnes (1997) argues strongly that community care needs to include community participation:

it has to involve rather more than the production of individualised care packages, based on professional assessment of needs. It has to involve enabling people to participate in

decision making processes about services, and in social, economic and political life more broadly. The concept of 'care' is an inadequate one to describe what it is that needs to be delivered in order to enable people to live their lives within communities.

(Barnes, M., 1997, p. 172)

And if the definition of 'community' is expanded beyond its strictly geographical meaning to take in the idea of moral communities (Abrams, 1978) or psychic communities (Inkeles, 1964), or what the Barclay Committee (1982) referred to as 'communities of interest', then it is possible to see community work methods being used in disability organisations. For example, as far back as the 1980s the Spinal Injuries Association employed a welfare officer whose job was to enable its members to work out their own problems and solutions by utilising the collective wisdom and experiences of its paraplegic members through mutual support, peer counselling and the provision of information and advice (d'Aboville, 1991). This has since expanded into a comprehensive peer support service (see [www.spinal.co.uk](http://www.spinal.co.uk)). Disabled people have also set up and continue to run centres for independent living (CILs) which undertake a community development role based on a social model (Barnes *et al.*, 2000a). CILs offer a range of services including mutual support in the use of direct payments (see [www.ncil.org.uk](http://www.ncil.org.uk)).

In suggesting that theory should inform practice with regard to disability rather than vice versa, a number of developments in social work practice compatible with the social model of disability have obviously been ignored. There have undoubtedly been initiatives by individual social workers or departments that are not based on the individual model, and are indeed perfectly compatible with a social model of disability. For example, Essex County Council set up independent living teams, but these are described as islands of social model practice within the authority (James and Hutchins, 2003). But social work as a profession has not given systematic attention to developing a theoretical perspective on disability. Even within the vastly growing literature on anti-discriminatory practice, there is little evidence, with the notable exception of Thompson (1993, 2001), of a sustained application of the combating of oppression in relation to disability. Neither is

there any sign of this in the USA, where Gilson and DePoy reach a similar conclusion: ‘for the most part, the academy has taken the diagnostic approach to disability, viewing disability as a medical phenomenon to be understood by professionals and treated through the provision of services and supports that counterbalance personal deficits’ (Gilson and DePoy, 2002, p. 157). Such theory has been developed elsewhere, notably by disabled people and their organisations. As a consequence, theory and practice have proceeded separately and have not merged into what was earlier called a ‘paradigm’ in respect of the individual model. It is crucial, however, that in future there is a merger between theory and practice in order to create an alternative paradigm to the one based on the individual model.

A useful framework for analysing the theoretical basis of services that can be used by social workers and their managers is that developed by Oliver and Bailey (2002) in a review of services in one local authority. The framework identifies three approaches to the provision of services: the humanitarian; compliance; and citizenship approaches.

#### **The humanitarian approach**

Under this approach, services are provided out of goodwill and the desire to help individuals and groups perceived as less fortunate. This leaves producers in control of these services, and users are expected to be grateful for receiving them. The outcome of this is often that producers think they are doing a good job, but users, when asked, are critical and are seen as being ungrateful.

This approach is set out in summary form below:

#### **Providers:**

- we know best;
- individual model – whereby the disabled person is the problem;
- doing clients a favour; and
- clients should be grateful.

#### **Disabled people:**

- don’t like being patronised;
- reject individual model;
- not valued as people; and
- services not reliable.

**Result:**

- conflict;
- lack of trust;
- inadequate services; and
- poor levels of satisfaction.

**The compliance approach**

Under this approach, services are driven by government policy and legislation. Obviously the Disability Discrimination Act, 1995 is of prime importance here in respect of services to disabled people, but other legislation such as the Community Care (Direct Payments) Act, 1996, the NHS and Community Care Act, 1990 and the Chronically Sick and Disabled Persons Act, 1970 are also relevant. This often means that producers adopt a minimalist approach, to both to the principles and practice of service delivery, and do only what is necessary to comply with the law or government regulations. Service users often feel disgruntled because they think they are being denied something they are entitled to.

This approach is set out in summary form below:

**Providers:**

- meet laws, rules and regulations;
- check list approach;
- minimum standards; and
- lack of commitment or partnership.

**Disabled people:**

- rights not fully met;
- going through the motions;
- still service- rather than needs-led; and
- staff tend to own the task not the aim of the service.

**Result:**

- conflict;
- denial of entitlements and expectations;
- inadequate services; and
- poor levels of satisfaction.

### The citizenship approach

This approach requires disabled people to be seen as full citizens, with all the rights and responsibilities that are implied.

There are three dimensions to this approach:

- disabled people are seen as contributing members of society as both workers and valued customers (users);
- disabled people are recognised as empowered individuals (voters); and
- disabled people are seen as active citizens with all that implies in terms of rights and responsibilities.

Only when all three dimensions are met will the relationship between providers and users of services be a truly harmonious one.

This is summarised below:

#### **Economic dimension:**

- disabled people as contributors/workers; and
- disabled people as customers.

#### **Political dimension:**

- disabled people (plus relatives and friends) as voters; and
- disabled people as powerful groups.

#### **Moral dimension:**

- disabled people are people too and have human rights.

Services to disabled people are still largely provided under the humanitarian and compliance approaches, and as some local authorities are already moving in the direction of a citizenship approach for other minority groups – for example, by setting quotas for the employment of people from ethnic minorities (Oliver, 2004) – there is no reason why they cannot do the same in respect of disabled people.

This has much in common with the ‘paradigm’ change being sought by Nelson *et al.* (2001) in relation to mental health in Canada. They argue that within the traditional paradigm, which includes medical-institutional and community treatment-rehabilitation approaches: people are treated as patients or clients, rather than citizens; the professionals remain in control; stigma, while recognized, is explained by individual deficits; and services are

segregated. On the other hand, the new paradigm they see emerging from within user-controlled services places an emphasis on: consumer/survivor participation and empowerment; integration and support; and social justice. There is a strong sense of people being 'cared about', rather than 'cared for' and this is shown in their adoption of a feminist concept of power 'that is no longer based on individualism and "power over", but instead emphasizes "power with" ' (p. 22).

The citizenship approach, which appears to have support within the rhetoric of current government policies, is the only one that is compatible with the social model of disability. We shall be making use of this framework in revising this book, we hope we shall be making some initial recommendations for changing and adapting the more traditional approaches to professional social work.

### **Conclusions**

To conclude this critical overview, it has been suggested that the track record of social work involvement with disabled clients has not been good. Social workers have either ignored disabled people and their needs or, when they have been involved, their interventions have been based on inappropriate assumptions about the nature of disability. Certainly, social work has failed to develop its theory and practice in terms of even the Seebohm view of seeing the disabled person in the context of family and community, let alone taking on board the implications of a fully developed social model of disability. There are, of course, reasons for this. Social work, like all other professions, has been unable to shake loose from the individual model generally embedded in social consciousness. It is also, of course, politically convenient to have the problem located in the individual – repeated requests for assistance can be explained away as signs of having a 'chip on the shoulder' or of a 'failure to adjust to disability'. More recently, the institutional structures within which social work operates have been organized to focus on the provision of services within strict budgetary limits. The rhetoric of 'needs-led' services has been outweighed by the instinct of organisations to ensure they are above criticism from a judicial review of their activities that would interpret need from an individual model.

The social model of disability has been articulated not just by individual disabled people, but by organisations of disabled people. As these developed in the 1960s and 1970s, it was possible to identify three distinct approaches adopted by these groups: the incomes approach; the self-help approach; and the populist approach. All these approaches, to a greater or lesser extent, built on the social model of disability, and such activities have tended to become consolidated, further exposing the contradictions between the individual and social models of disability. Today, some of the leaders from these organisations have moved into influential positions within the institutions set up to govern social work, and the message of the social model can no longer be ignored.

The social work profession has made some attempts to join with disabled people and their organisations – for example, the BCODP–BASW conference in Birmingham in 1986, though few formal links have been sustained. For many years it appeared to be the occupational group best placed to play a supportive role in the development of a new paradigm as, despite criticisms, it is possibly less tied to the individual model of disability than are paramedical professions such as occupational therapy, and it has a range of methods of work, skills and techniques that are well suited to working within the social model of disability. The rewards for social workers would arise from the enhanced professional and personal satisfaction that stems from both the increased range of tasks in which to exercise professional skills, and the greater potential for achieving change. In working with disabled people the social work task can no longer be one of adjusting individuals to personal disasters, but rather in helping them to locate the personal, social, economic and community resources to enable them to live life to the full.

In the following chapters, some of the themes developed will be pursued in relation to issues concerning social work practice. It should be re-emphasised, however, that this does not mean that what follows will be a practical manual on ‘how to do social work with disabled people within the social model of disability’. Rather, it will be an orientating perspective enabling social workers to develop their practice in conjunction and in partnership with their disabled clients.

### putting it into practice

#### Exercise 1

It has been argued in this chapter that the individual model of disability has dominated social work. One factor in this domination is the language we use. A useful exercise is to examine the language being used to describe disabled people in conversation, in newspapers or on the TV. For example; what does the term 'wheelchair-bound' mean? Why are people referred to as 'sufferers'?

1. Make a list of all the words or phrases you find or have heard and decide if they are negative, positive or neutral.
2. Ask yourself how they influence the way you think about disabled people.
3. Ask yourself if these terms make you more or less fearful of impairment.

#### Exercise 2

Take the characteristics (below) of the Humanitarian and Compliance approaches to welfare attributed to providers and use them to examine the approach of a welfare society with which you are familiar.

##### *Humanitarian*

- we know best
- individual model – whereby the disabled person is the problem
- doing clients a favour
- clients should be grateful

##### *Compliance*

- met laws, rules and regulations
- check list approach
- minimum standards
- lack of commitment or partnership

Discuss and decide what changes would have to be made for that agency to move to the Citizenship approach.

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