



COT/ BAOT Briefings

The Social Model of Disability

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Introduction

This Briefing identifies various papers and publications that present the social model as a framework by which to understand and view disability. The model can influence the approach that is taken to disability and disabled people and can be used to shape the provision of health and social care services. At times the papers contrast the social and medical models of disability. The Briefing will not explain the history and development of the model in detail, but references are provided where such information is available.

For the purposes of this Briefing the definition of a model for practice is taken from the glossary of *Occupational therapy defined as a complex intervention* (2003). This states that a model is 'a simplified representation of the structure and content of a phenomenon or system that describes or explains certain data or relationships and integrates elements of theory and practice' (Creek J, 2003, page 55). Thus the social model of disability can be seen as a way of explaining and understanding disability, of understanding the relationship between disability and society or the environment, and of structuring the provision of services for the disabled, including health and social care.

The social model of disability has been widely adopted by the disabled community. It is being used to support the disability movement as it challenges the way people view disability. The model recognises that some people have impairments that affect how they function physically or mentally. However, it sees that the disability these people experience is as a result of the barriers put in place by a society that does not recognise or take account of their needs.

Shaw (2001), in her work for the National Disabled Persons Housing Service Ltd, used the social model to shape her definition of disability as, 'the loss or limitation of opportunities to take part in the mainstream life of the community on an equal level with others due to physical and social barriers' (Shaw 2001, p7). Alongside the social model of disability, it is important to understand that independence is more than being able to move or function without assistance, but means that disabled people have control and choice over their own lives. This is a definition supported by the National Centre for Independent Living (NCIL).

Some writers agree that it is inappropriate to link disability completely with a medical condition, disease or illness, but they recognise that for some people symptoms like pain



do have a disabling or limiting effect and that the social model should include or recognise this (French 1993 in Picking C 2000)

Picking C (2000) in her chapter *Working in partnership with disabled people - new perspectives for professionals within the social model of disability*, identifies the challenge that the social model of care represents to the caring professions. She states that even the value of rehabilitation itself is questioned, when the aim of rehabilitation is to restore the disabled person to 'normality' and the therapist's priority for independence is one of enabling disabled people to do things for themselves. It is argued that independence 'is more a state of mind than a physical ability and an individual achieves self-determination, by having control over their life, notwithstanding being highly dependent upon another person' (Campbell 1994 in Picking C 2000, p 18)

Picking illustrates her point across a series of themes, including assessment, equipment and adaptations and others. She discusses achieving a new approach that is a real change in attitude. This involves listening to what disabled people say, as formal groups or as individuals, recognising their priorities, their choices and their right to take risks. Disabled people should not be stereotyped as passive recipients of care, but take an active part in discussion, planning and decision-making. Picking quotes a definition of rehabilitation as 'a process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social function' (Wilson and McLellan 1997, in Picking C, p 25). This, she says, 'implies that the purpose of rehabilitation is to assist disabled people in achieving the lifestyle of their choice (Picking C, p 25). Picking concludes that health and social care professionals should be seen as a resource to be drawn upon, offering knowledge and expertise. Thus the profession would become more of an intermediary or consultant, providing information upon which decisions can be based.

The following papers and publications describe the application of the social model of disability in a selection of settings. It is possible to identify the core principles of the social model in the papers, and to see how they can change the approach taken to disabled people and the services that are offered to them. Readers are recommended to obtain and read the relevant papers fully for more detailed information. Other relevant papers are also listed at the end of the Briefing under Bibliography.

▪ **Research**

Bochel and Bochel (1994) suggest that acceptance of the social model of disability has significant implications for research. It would affect the research methods and the type of information collected. The use of a medical or social model would lead researchers to take very different approaches. For example, in the assessment of disabled peoples' needs with regard to housing, health and social care, a medical model approach might involve counting people with disabilities, assessing their problems and looking at their housing and care needs. This would provide information such as the number and type of housing adaptations required, the number of care workers and the type of care required. A social model approach might involve the examination of which buildings, facilities and services are not accessible to disabled people, looking at the barriers and also asking disabled people about what they feel they need. This would provide a



measure of the limitations of the building, or an 'index of oppression', along with a description of peoples' expressed needs.

The article recognises that there are shortcomings in either approach. Although a social model approach provides valuable information on the needs of disabled people, it does not always provide the information in terms of hard numbers that might be required for the planning of services. The article describes an attempt to move towards a more social model approach to research, then discusses the pros and cons of the experience in terms of research outcomes.

▪ **Learning disabilities**

Coles (2001) draws on research and current debate to look at whether the social model of disability can inform the delivery of services for people with profound and complex learning disabilities. He also tries to describe what distinguishes practice that is influenced by the social rather than medical model, being particularly concerned with social care. Cole describes in detail some small-scale research into the influence of the social model on the relationship between people who use services for those with learning disabilities and their support workers, and on the care provided. The research looked for evidence of the existence of the social model of disability in the relationships, for example approaches which sought to offer choice, based on the service user's needs and wishes rather than professional judgement. It also looked at how those with learning disabilities were accepted and helped to live their chosen lives to the full, within their local communities and using ordinary facilities. Through the description and comment, it is possible to see how the social model can be used to shape practice, in terms of the approach taken to communication, actions and relationships.

▪ **Mental health**

In their paper Williams and Heslop (2005) argue that the medical model has dominated thinking on support for people with learning disabilities who experience mental health problems and that the social model could have much to offer. The authors suggest that the medical model focuses on what is wrong with an individual, classing people by their medical diagnoses and managing their symptoms, for example hearing voices or self-harm, through medical intervention. The social model of disability may see these behaviours as responses to the situations or experiences that the individual finds him/herself in. It is these situations or experiences that may need to be changed in order to relieve the distress that the person feels.

The paper goes on to discuss a research-based project, Mind the Gap, that was based on the social model. The project piloted an approach that focussed on the person's needs rather than their diagnosis, taking account of social and practical support alongside biomedical interventions. The approach sought to bring together all the assistance on offer so that people with a learning disability and their families were enabled to be in more control of their lives. The paper clearly recognises that there is a need to tackle the social barriers and disadvantages faced by these people, as being the root cause of much of the mental distress they experienced.



▪ Housing

In Shaw's (2001) good practice guide for Registered Social Landlords (RSLs), the social model is applied to each element of the process of assessing for and providing suitable housing for disabled people. This includes looking at wants, needs, resources, policies, principles and user involvement. The guide encourages the adoption of the Disability Discrimination Act 1995's definition of disability, providing detailed guidance on its application. It also examines the role of the occupational therapists in helping to prioritise applications for adaptations, recognising that the underpinning philosophy of the profession includes the social model. Even so, many occupational therapists still work within a resource-led environment, where the perspective needs to be changed to one of being needs-led.

Oldman (2002) argues that the social model of disability can be a vehicle for analysing and improving housing policies for older people, making environments less disabling. She proposes that the social model considers, not just the home itself, but the neighbourhood and social context in which it is set. The social model recognises that the domestic environment, when inappropriate, can restrict an individual's access to vital social and personal relationships, leading to poor mental health. In conclusion, Oldman suggests that the social model can be a means for collective action by older people, in order to change their own situation.

Hawkins and Stewart (2002) reviewed the literature looking at the value and meaning of the home and how this needs to be considered in any adaptation process. The authors suggest that the functional limitations of the disabled person are sometimes considered in isolation from his or her experiences and roles, resulting in a mismatch between the adaptations considered and the symbolic meaning of the home environment to the disabled person and his or her family.

A number of examples are given, where the importance of value and meaning are not always considered. In the construction of special needs housing, the appearance of the building and its location are important to its acceptance. Individual features and adaptations can emphasise disability and the location of special needs housing in clusters can increase its segregation from the surrounding community.

The article goes on to suggest a number of ways in which beneficial adaptations can be made, without compromising the value and meaning of the home. This introduces a social model approach to assessment and design, encouraging a more holistic consideration of the person and the environment in which he or she lives. The potential role of the occupational therapist is seen as an advocate and intermediary, drawing in and including service users at all levels of housing provision and social integration.

Conclusion

The concepts incorporated into the social model of disability are familiar to occupational therapists, but their application into practice can be challenging, especially in a large organisation or environment that is dominated by a medical model of care or is controlled by financial or performance targets. Fully understanding the social model of disability will help occupational therapists to shape their approach to disabled people



and to work successfully in partnership with them. How its concepts are applied in a service is for local discussion and debate.

Occupational therapists are ideally placed to introduce and champion a social model approach to disability, encouraging their colleagues to see beyond the boundaries, to look at the social and environmental elements of a person's situation, which may be contributing to their perceived problems. The papers described in this Briefing demonstrate that the social model of disability can be used to shape services in a variety of ways and settings. Most fundamentally, it can influence the way that professionals think about, approach and communicate with their service users. The care process, the purpose and outcomes of intervention and the terminology used can all be subtly altered with a social model approach that values the service user as an individual with rights and choices, an equal partner in their journey of care.



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Web sites

National Centre for Independent Living

www.ncil.org.uk/default.asp

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