

A Paper for the Health and Social Care Committee on The Social Model of Disability as a Basis for Transforming Social Services

Introduction

This paper is a supplement to Disability Wales (DW) submission in response to the Health and Social Care Committee consultation on the Social Services and Well-being (Wales) Bill (the SSW Bill). The original submission, supported by 36 organisations representing the full spectrum of impairment groups, recommended an amendment to the SSW Bill to replace the Medical Model definition of disability with a Social Model definition.

This paper, which has similarly been drafted in close consultation with key cross sector partners – including citizens and service recipients – will develop the case outlined in the original submission under *1. Definition of Disability*, which the Committee are asked to read in conjunction with this paper. It will explain why the SSW Bill must be founded on a Social Model definition of disability if it is to achieve the Welsh Government (WG)'s aim of fundamentally transforming Social Services and the way they are delivered.

In considering the SSW Bill it may be helpful to question how will it enable disabled people and other citizens to become more independent in their own lives and included as active contributors within their communities?

Why models matter

Conceptual models are "mental constructs that describe aspects of the physical and social world for the purposes of understanding and

communication...They help us to think about and solve problems" [1].

There are numerous ways of conceptualising disability, some of which focus more on the individual, while others are more concerned with the organisational and social aspects of disablement. These include Normalisation (in Learning Difficulties), the Recovery Model (in Mental Health), the Biopsychosocial Model (again in Mental Health, but also more broadly and now adopted by the UK Government as the basis for its welfare reforms), and the Rehabilitation Model, which is designed to "facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible" [2].

The latter has its roots in the Medical Model of disability, "a sociopolitical model by which illness or disability, being the result of a physical condition, and which is intrinsic to the individual (it is part of that individual's own body), may reduce the individual's quality of life, and causes clear disadvantages to the individual" [3].

Thus, the underlying assumption of the Medical Model is that impairments and health conditions are the cause of disability.

Unlike most of the other models, which were developed almost exclusively by academics and medical professionals, the Social Model was developed by disabled people out of their own experience of living in society with impairments and health conditions.

The Social Model makes a clear distinction between impairment and disability.

Impairment is defined as:

An injury, illness, or congenital condition that causes or is likely to cause a long-term effect on physical appearance and/or limitation of function within the individual that differs from the commonplace.

Whereas disability is defined as:

The loss or limitation of opportunities to take part in society on an equal level with others due to institutional, environmental and attitudinal barriers.

Other models, including the Medical Model, tend to view people who

have impairments and health conditions as having a "deficit" which causes them to suffer a "personal tragedy" which makes them "abnormal", in need of a cure, and deserving of charity. This places responsibility for disability very firmly on the individual and leads to a perception of service users as "passive recipients of care".

In contrast, the Social Model identifies the cause of disablement as the systemic barriers, negative attitudes and social exclusion which people experience *on top of* impairments and health conditions.

The Social Model therefore recognises that we have a collective responsibility for addressing the social, environmental, institutional and attitudinal barriers to equality, rights and social inclusion that people with impairments and health conditions face on a daily basis.

When people who have impairments or health conditions become aware of the Social Model, many experience a sense of liberation from the sense of burden which the Medical Model places on them – a similar experience to that of women recognising the oppression of patriarchy. The Social Model may therefore be characterised as empowering for individuals and has major implications for the way that services are assessed and provided.

It should be stressed that the Social Model and the Medical Model serve two different purposes, both of which are important and valid. However, problems arise when one model is used for a purpose that it is not designed for. For instance, someone with a broken leg does not want medical professionals to address this problem from the perspective of the Social Model. They want their body fixed, not society.

Conversely, the Medical Model should not be used as a basis for addressing the social, environmental, organisational and attitudinal barriers which, in the experience of many disabled people, are the real causes of disablement.

The transformative potential of implementing the Social Model of Disability

DW's original submission stated:

A SSW Bill based on the Social Model of Disability would catalyse a

fundamental shift in thinking about how Social Services are delivered. Instead of focusing on mitigating the impact of impairments and health conditions on individuals' lives – thus perpetuating the existing 'deficit model' of Social Services – a Social Model approach would focus on supporting disabled citizens to identify and remove the institutional, environmental and attitudinal barriers which cause "the loss or limitation of opportunities to take part in society on equal basis with others".

A system of Social Services based on implementation of the Social Model of Disability has genuine potential for achieving WG's aspirations for fundamentally transforming Social Services and the way they are delivered.

The current system of "care management" has been characterised as "a gate-keeping system in which Social Workers essentially manage access to social care resources by determining the eligibility of those seeking support" [4].

In contrast, a more personalised approach "will create opportunities for the use of social work skills in supporting people using social care support in developing choice and control in their lives" [ibid].

Choice and control is a fundamental concept of Independent Living, which "enables us as disabled people to achieve our own goals and live our own lives in the way that we choose for ourselves" [5]. It refers to individuals' right to determine what, how and when support is provided, and by whom.

DW's original submission to the Committee advocated for enjoyment of the Right to Independent Living to be incorporated into the meaning of well-being set out in the Bill. The Right to Independent Living is enshrined in Article 19 of the UN Convention on the Rights of Persons with Disabilities [6].

The Social Model provides an appropriate framework for making choice and control a reality in Social Services by addressing the social, environmental, organisational and attitudinal barriers to Independent Living.

A system of Social Services based on a Medical Model definition which places responsibility for disability on individuals and their perceived

deficits clearly lacks this transformative potential.

Applying the Social Model of Disability within Social Services in Wales

The Social Model has proved to be a durable and insightful way of understanding the experience of disablement in society. It very effectively highlights the disabling impact of a wide range of social barriers on people who have impairments and health conditions.

In applying a Social Model approach to assessment as well as identifying the unique set of barriers that prevent an individual from enjoying their right to Independent Living, it will also enable individuals to make their unique contributions to their communities.

It requires Social Workers to consider individuals' unique circumstances in a more holistic way, simultaneously addressing both the negative impact that social barriers have on their lives and the positive contributions they can make to their communities if their assets are recognised, valued, developed and deployed.

How a SMD approach to assessment would work in practice

An SMD approach to Social Services assessments would provide a foundation for implementing Citizen Directed Support (CDS). The CDS model is outlined in DW's original submission under section 3. *Citizen Directed Support*.

The entire focus of Social Services departments would switch from care management (i.e. gate-keeping access to available resources) to ***facilitating individuals to achieve Independent Living and participate in their communities***. Independent Living is achieved by removing the social, environmental, institutional and attitudinal barriers that disable people.

In carrying out an assessment Social Workers would start by initiating a conversation with the individual and their circle of support (family, friends, advocate, professionals etc) based on existing Person Centred Planning models of assessment, and the Talking Points Personal Outcomes Approach (see section 9. *National Outcomes Framework*, in

the original paper).

This will enable the Social Worker to build a picture of the individual's personal circumstances, their relationships, the practical support they require, their goals and aspirations, and the outcomes they wish to achieve. Consideration will be given to how community based resources can be accessed.

The conversation would then focus on facilitating the individual to identify the barriers to Independent Living that they experience. The Social Worker would work with them to co-produce a plan for eliminating or reducing the impact of these barriers on their lives.

The final part of the assessment would identify the individual's skills, gifts, qualities and experience, and consider how these can be further developed (if necessary) and deployed in their community. This may identify additional barriers to social inclusion to be addressed in the support plan. Consideration will be given to identifying time banking and similar opportunities for community engagement.

The above process may be described as ***Citizen Directed, Outcomes Focused, Supported Self-Assessment***.

It is a universal approach to assessment and support planning which can be applied to all individuals, regardless of their impairments or health conditions.

It enables a personalised approach to social support with the potential to transform not only individuals' relationships with their services, but also with their communities.

What are the first steps?

Implementation of the Social Model of Disability as the basis for the SSW Bill will require significant culture change within Local Authorities. Whilst some will welcome the challenge of re-conceptualising the way they provide services, others may be more resistant.

Whilst responsibility for initiating culture change lies with the Local Authorities themselves, strong leadership from WG is vital. There appears to be growing acceptance of the principles of Co-production

within WG and the National Assembly. However, we suggest that in the context of the vision outlined in *Sustainable Social Services*, there is a need to progress to the next level by putting Co-production into practice.

The Wales Alliance for Citizen Directed Support and the Wales Co-production Practitioners Network have gained some expertise in this and can make a valuable contribution if they are given a more central role in moving the transformation agenda forward. We suggest that a practical first step would be to hold an exploratory conversation about implementing Co-production between these organisations and the Welsh Government.

Several third tier organisations will also have a key role in ensuring that this agenda for transformational change is progressed with consistency across Wales, including ADSS Cymru, WLGA, the Care and Social Services Inspectorate Wales, and the Care Council for Wales.

We would wish to see similar conversations taking place involving senior representatives from these and other public, private and third sector organisations, together with other stakeholders and citizens, with a view to developing the agenda for transformational change on a co-productive basis.

These conversations should include consideration of the potential value of incorporating a Talking Points Personal Outcomes Approach to monitoring and evaluation, as discussed in the original paper under section 9. National Outcomes Framework.

We strongly believe that effective Co-production is the critical success factor in transforming Social Services in line with the Social Model of Disability. By working together co-productively, with due consideration being given to all stakeholders' voices and expertise – including, importantly, citizens and service recipients – the practical mechanisms for transforming Social Services in line with the principles of Citizen Directed Support, can be expected to emerge. We anticipate that co-productive engagement with citizens will result in consensual support for the systems and processes that stakeholders co-design.

References

- [1] http://en.wikipedia.org/wiki/Conceptual_model
- [2] <http://medical-dictionary.thefreedictionary.com/Rehabilitation>
- [3] http://en.wikipedia.org/wiki/Medical_model_of_disability
- [4] Personalisation of Social Care & The Future of Care Management: Reflections from a Care Services Improvement Partnership Seminar 19th July 2007
www.dhcarenetworks.org.uk/library/Personalisation_of_Social_Care.doc
- [5] Disability Wales, 2010
- [6] UN Convention on the Rights of Persons with Disabilities
<http://www.un.org/disabilities/convention/conventionfull.shtml>

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