

MODELS OF DISABILITY

This fact sheet covers:

- **What is a model.**
- **Modelling disability.**
- **The medical model.**
- **The social model.**
- **Outcomes of the medical and social models.**
- **Placing direct payments within the context of the social model.**

1. Introduction.

Some might wonder why those concerned with the practicalities of implementing direct payments should concern themselves with theoretical or philosophical debates about the modelling of disability. However, implementing direct payments successfully will not only require new administrative and financial systems, but also a change in the whole culture of service delivery. This can crudely be characterised as a shift from a 'medical' model approach, where professionals make decisions for their passive clients, to a 'social' model approach where service users are empowered to make decisions for themselves. As will be discussed, the way in which disability is understood, what causes disability and how it can be addressed, can lead to very different directions for policy and practice.

This fact sheet provides a brief explanation of two models of disability. It concentrates on the basic distinctions between the two fundamental models. A list of further reading is provided for those who wish to pursue the ongoing debate about modelling disability.

2. What is a Model?

In common parlance, a model is a simple, and sometimes simplistic, representation, to help grasp the more difficult properties of a real-life situation, or to explain or interpret a phenomenon.

One type of model might be of the sort used by town planners or architects, or by civil engineers before they proceed to build a bridge. The purpose of such models is to help visualise the end product, or to test whether the bridge will fall down before it is built. But models can also be made of ideas rather than wood or plastic. Mathematicians and physicists, like Einstein, use modelling to explain their theories. In a similar way, social scientists theorise about how people live and work together in terms of certain kinds of political or philosophical thinking. Whereas mathematicians and physicists use letters, numbers and symbols to represent their ideas, social scientists use definitions and principles. The purpose of social theorising may be to predict, but it may also be to offer an explanation or interpretation of a social phenomenon or problem; medical and social models of disability fulfil the same function. Depending on how an issue's causes are understood, different social policies and practices may be selected to address it. Therefore, if understanding is wrong or misguided, so too will be the policies and practices. At worst, far from overcoming a social problem, they may end up compounding it.

3. Modelling Disability.

Within the field of disability two major models compete for acceptance. Both are advocated by different groups of people who have had different experiences within the social history of disabled people. Space does not allow for this history to be detailed in this fact sheet, but it should be recognised that each model comes from the perceptions of the main players in the saga of society's reaction to, and treatment of disabled people throughout the ages.

i. The Medical Model of Disability.

What is now described as the medical model emerged from the approaches traditionally taken towards disabled people by people from the caring and welfare professions. These were people empowered by society to 'cure' or 'care' for disabled people, often in institutions segregated from the rest of society. Variations of the medical model are to be found in the 'charity' or 'administrative' models. Like doctors, administrators and other health and social welfare professionals in both statutory and voluntary organisations have based their work ethos on the

medical model's assumptions. The way services have traditionally been delivered has been a logical outcome of this model. Sometimes it appears as the 'individual' model, in contrast to the 'social model'. In whatever guise, this model locates the problem with disabled people rather than with society. As such, it implies that the way to overcome barriers to inclusion is to 'adjust' the individual disabled person in order to 'fit' society, rather than adjust society to accommodate disabled people.

The Medical Model of Disability describes the restrictions and limitations in the lives of disabled people as resulting from their impairments.

ii. The Social Model of Disability.

This was devised by disabled people, whose experience of the health and welfare system, as well as society's general reaction to them, made them feel socially isolated and oppressed. The denial of opportunity, the restriction of choice and self-determination, and the lack of control over the support systems in their lives led them to question the assumptions underlying the dominance of the medical model. They therefore set out to develop an alternative, which has now grown in ascendancy.

The Social Model of Disability describes the restrictions and limitations in the lives of disabled people as resulting from environmental, attitudinal and organisational barriers within society.

The definitions and language they use comprise the underlying assumptions of these models. Likewise, the outcomes, including the type of service developed, depend on such assumptions.

iii. Definitions and Assumptions of the Medical Model.

As stated, this model was developed by people, primarily non-disabled people, whom society had authorised to either "cure" or "care" for disabled people, predominantly in segregated institutions.

It came from the perception of people who viewed "normality" in terms of "able-bodiedness". These were people trained within a system of health and welfare which had denied choice, looked upon disability in terms of deviancy theory and which had evolved within a social history of partition and punishment.

The medical model was an attempt to distinguish between the terms "impairment", "disability" and "handicap". There was confusion between

these terms because they were used analogously. The medical model defined each as follows:

"IMPAIRMENT" was any loss or abnormality of psychological, physiological or anatomical structure or function.

"DISABILITY" was any restriction or lack of ability (resulting from impairment) to perform an activity in the manner or within a range considered normal for a human being.

"HANDICAP" was any disadvantage for a given individual (resulting from disability) that limited or prevented the fulfilment of a role which was normal (depending on age, sex, and social and cultural factors) for that individual.

Therefore, according to the medical model of disability, for someone with neurological damage:

Their **"IMPAIRMENT"** may be cerebral palsy.

Their **"DISABILITY"** may be that their speech, hands and legs do not function in a manner considered by others (such as doctors) to be "normal" for a human being.

Their **"HANDICAP"** may be that they cannot adopt a "normal" role, such as that of a passenger stepping onto a bus.

iv. Definitions and Assumptions of the Social Model.

The social model, which comes directly from disabled people's own personal experiences, sees disability as something totally distinct from impairment. It states:

"IMPAIRMENT" is lacking part or all of a limb, or having a defective limb, or other part of the body.

"DISABILITY" is the disadvantage, or restriction, caused by a contemporary social organisation, which takes no, or little, account of people who have impairments and therefore excludes them from participation in the mainstream of social activities.

"DISABILITY" is, therefore, a particular form of social discrimination.

So, according to the social model, for someone with neurological damage:

Their "**IMPAIRMENT**" may still be cerebral palsy.

But their "**DISABILITY**" is society, with its physical, psychological and organisational barriers.

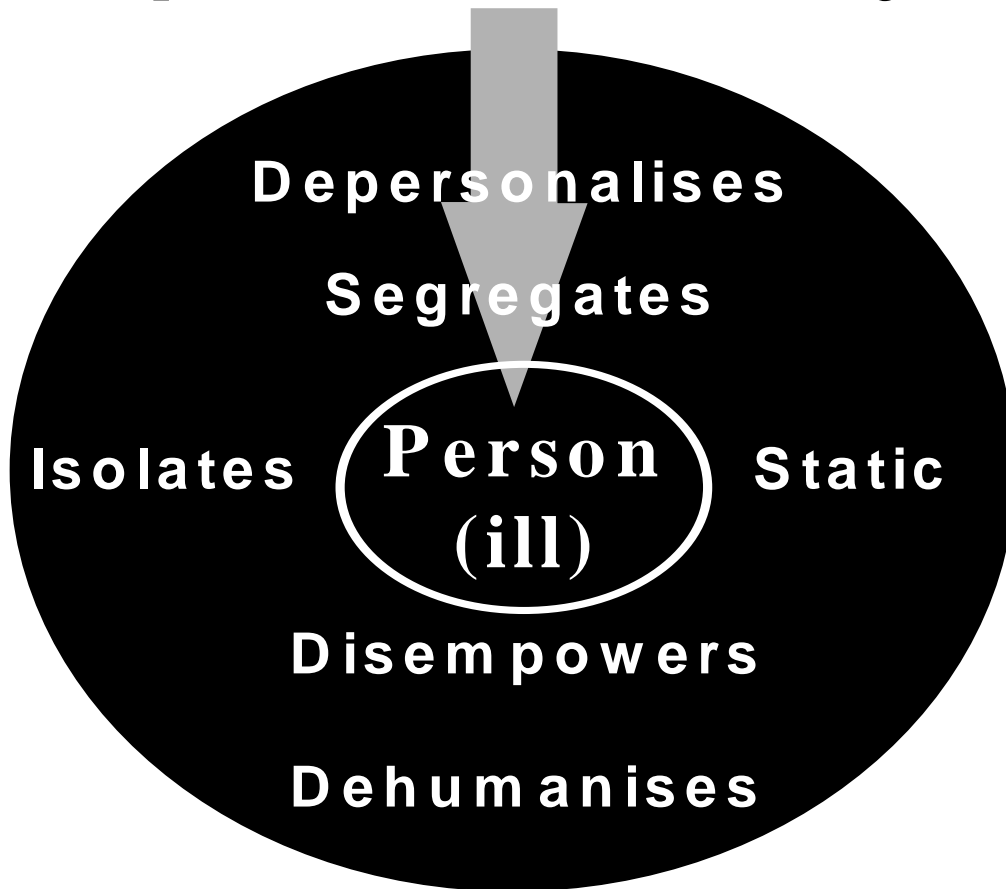
v. Assumptions and their Outcomes .

The assumptions behind the different models and the outcomes which ensue from them in effect express different sets of expectations about disabled people's roles and responsibilities within society.

First, what are the assumptions of the **medical model**?

- The person is in a tragic situation.
- S/he has a loss and is disadvantaged.
- The disability is part of the individual - it belongs to her/him.
- The disabled person's decision-making functions are inevitably impaired.
- Successful rehabilitation is seen in terms of the number of tasks that can be done without help, rather than the number of tasks which can be organised and directed with help.
- The expectation is that the status quo of society is fixed; the person has to adapt to fit society.

MEDICAL MODEL
Impairment = Disability



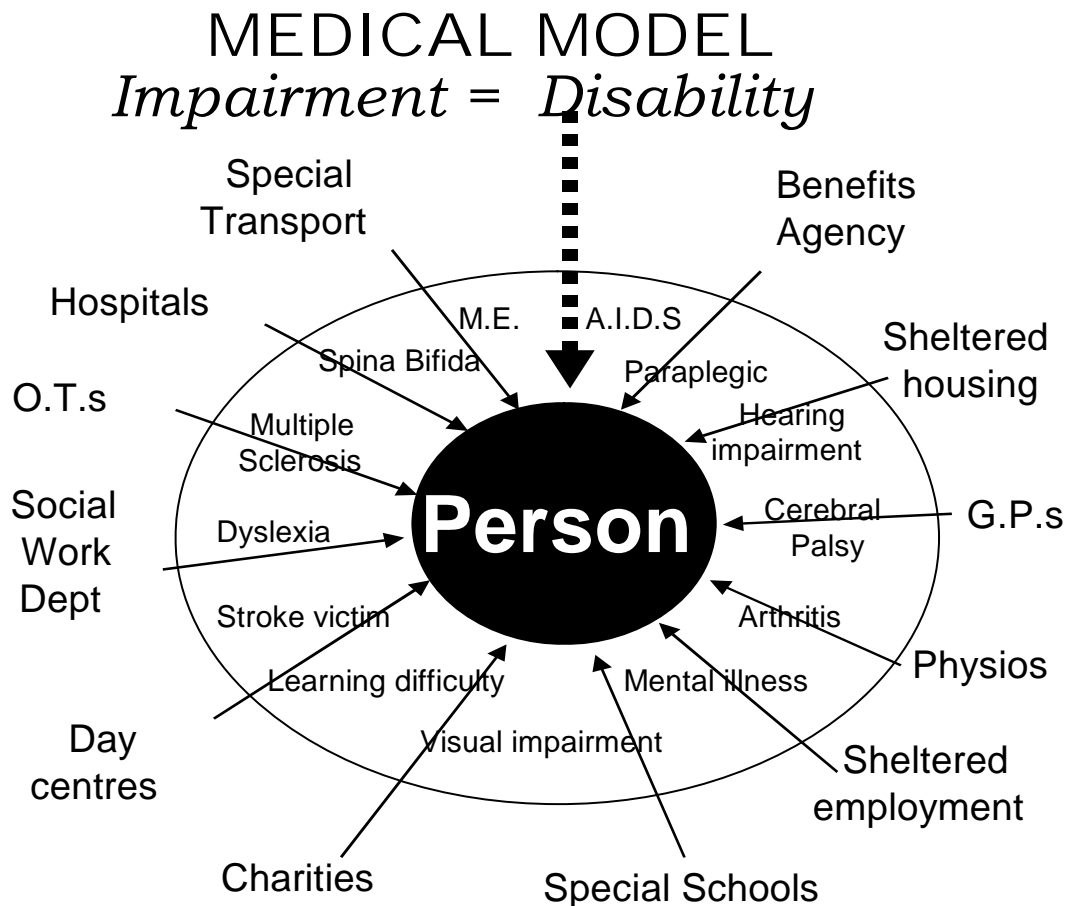
Grant Carson - The Centre for Independent Living in Glasgow (1999)

The medical model sees the person as being deviant and in need. It depersonalises and disempowers her/ him. In addition, segregating the disabled person from society minimises society's motivation to promote equality and inclusion.

Second, what are the outcomes of the **medical model**?

- A philosophy of 'cure or care' permeates service delivery.
- The uncured persons are segregated from the rest of society, and each other.
- An industry of professionals and volunteers develops around the disabled person with her/him being seen as the commodity.
- Allocated resources designed to overcome disability are managed by professionals and administrators.

- The social control mechanisms of welfare services make sure that changes to the structure of society do not take place, because those who do not 'fit-in' are dealt with elsewhere.



Society's responses to a disabled person in terms of The Medical Model

Grant Carson - The Centre for Independent Living in Glasgow (1999)

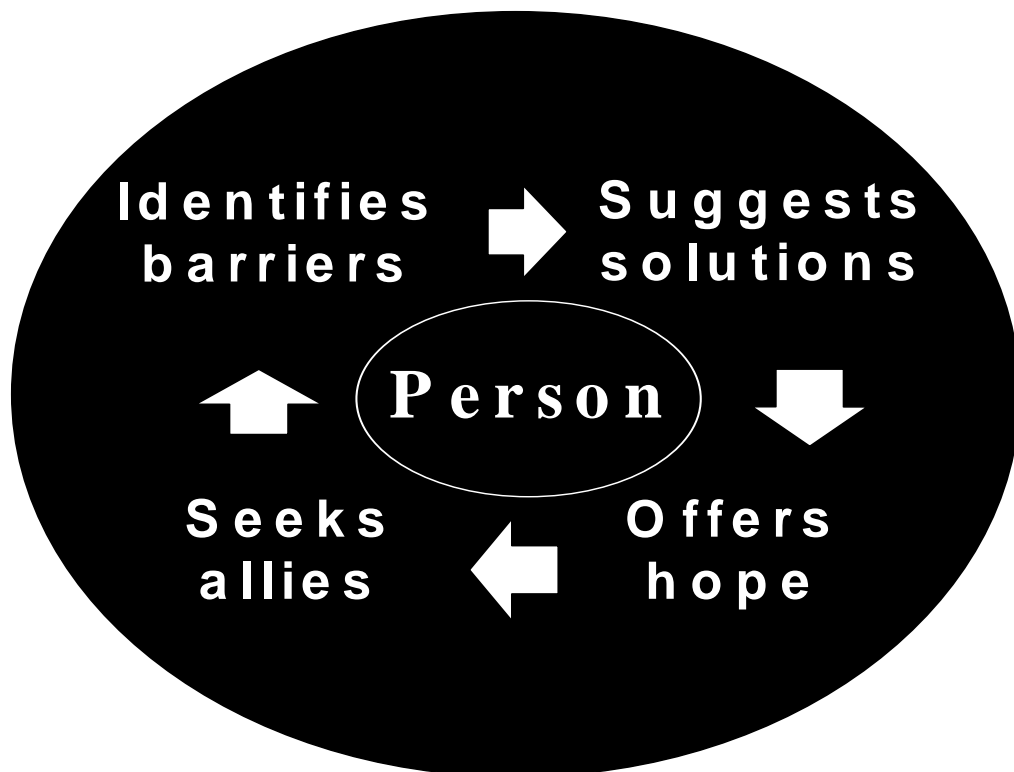
Now, what are the assumptions of the **social model**?

- The disabled person is seen as an oppressed group within society.
- Disability is not part of the individual - it is part of society's physical structures, its psychological make-up and its sociological organisation.
- The disabled person can make her/his decisions, or can be supported in her/his own decision-making process.
- Independence is seen as the ability to organise and direct support to accomplish tasks - rather than as being able to do them oneself

society can change to be more accommodating to all minority groups.

- Disabled people and their allies have the power to change society.

S O C I A L M O D E L *Barriers = Disability*



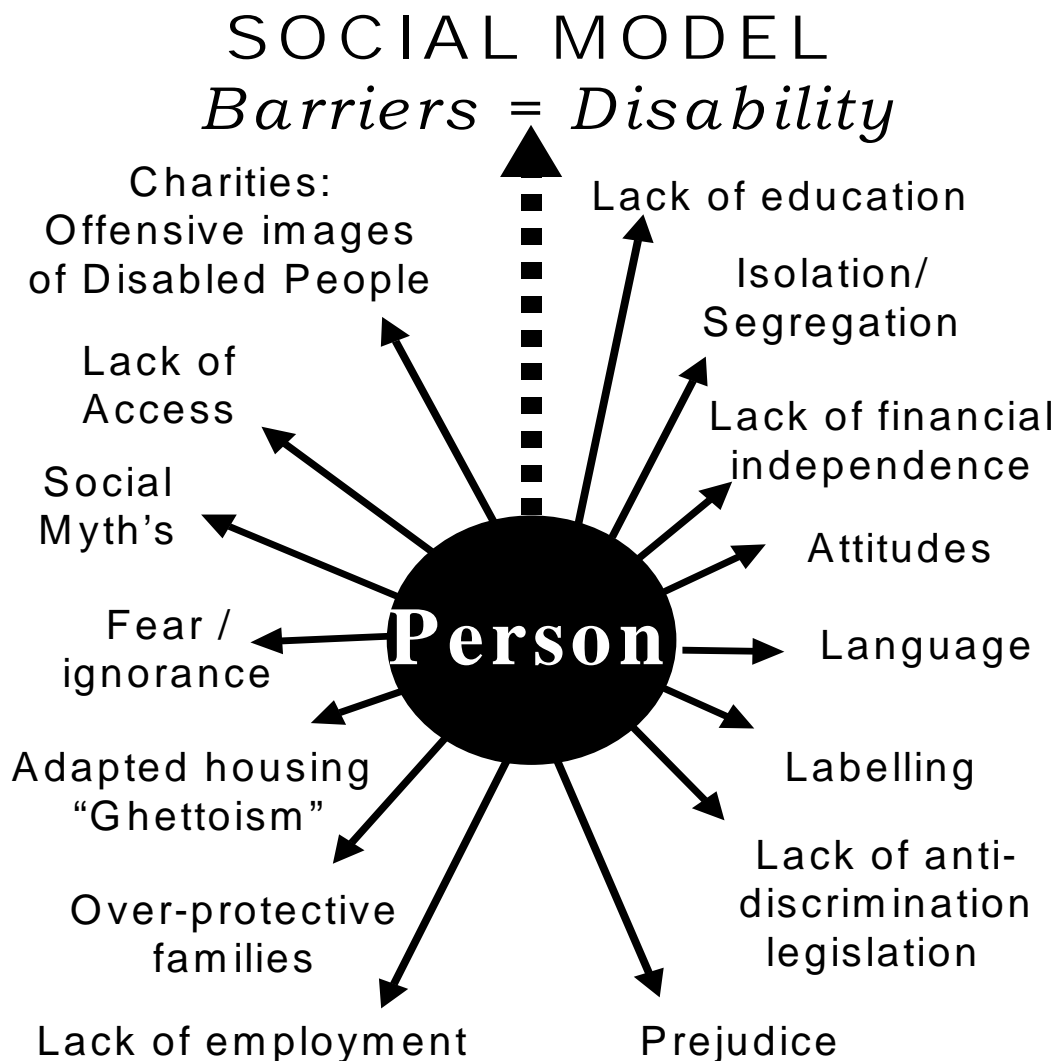
Grant Carson - The Centre for Independent Living in Glasgow (1999)

Therefore, the social model empowers disabled people to identify barriers within society which inhibit their full and equal participation. It also empowers disabled people to put forward their own solutions to overcome those barriers. It offers hope and motivation, allowing disabled people to seek allies among other oppressed groups who may face similar barriers.

Finally, what are the outcomes of the **social model**?

- Disabled people can unite with one identity.
- A philosophy of enabling the socio-economic involvement of disabled people in society drives service delivery.

- An industry of advice and support workers develops around the disabled person with her/ him at the helm.
- Allocated resources designed to overcome disability are controlled by the disabled person.
- Disabled people can integrate into society on their own terms rather than adapt to it on other people's terms.



**It is the Barriers present in
society that really disable people**

Grant Carson - The Centre for Independent Living in Glasgow (1999)

4. Placing Direct Payments within the Context of the Social Model.

It can be seen from the outcomes of the social model that disabled people are empowered through a combination of advice, training and support to make choices as to what to do with their lives and how to live them. Direct payments are the allocated resources needed to overcome

the barriers in society which disable people. Direct payments are managed by disabled people to organise and direct systems of support to overcome an obstacle in the way of an objective. If the obstacle is getting dressed to go to work, or going to the pub to meet some friends, then the person can use the direct payment to employ someone to assist them to overcome the barriers of dressing and going to the pub. The direct payment is used by the disabled person to achieve her/ his desired objectives of working or meeting friends. The provision of direct payments therefore enables the socio-economic involvement of disabled people in society. They allow disabled people to integrate into society on their terms and in a manner of their choosing.

5. The Debate over Modelling Disability.

The debate over modelling disability continues. The culture and working practices that have grown up around the medical model still too often predominate amongst both professionals and sometimes disabled people themselves. It can be all too easy to believe that you are needy and helpless, if professionals and others continually treat you that way. Disabled people who have believed the image of themselves as passive and needy often find this reflected by the professionals they encounter. This creates practical problems for, or barriers and challenges to, promoting the widespread adoption of the social model.

The main criticism of the social model is that, taken to an extreme, it suggests that disability would be eradicated if society was changed in the appropriate ways. For example, disabled people could do any job if only attitudes changed, the environment was accessible and work was organised appropriately. It also does not acknowledge the limitations which may result from impairment (e.g. pain) that no amount of change to the social context could remove.

Various attempts have been made to bridge the gap between the social and medical models. Most recently the World Health Organisation published its "International Classification of Functioning, Disability and Health" (ICF). In its introduction it states:

"ICF is based on an integration of these two opposing models. In order to capture the integration of the various perspectives of functioning, a 'biopsychosocial' approach is used. Thus, ICF attempts to achieve a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective".

In effect this seems to suggest that it is possible to combine the medical and social models in order to understand disability (or health – but the two are not necessarily the same) from different perspectives. It might be taken to mean that both models can co-exist rather than that they must be mutually exclusive alternatives. Or, it might simply be taken to imply that there may be things that could be done to ‘adjust’ both the individual and society to smooth the interface between them and thereby promote inclusion. There are concerns about whether combining them makes the direction for policy and practice less clear, and whether indeed it is possible to apply it in practical ways.

Whatever its potential usefulness, or lack of it, the fundamental principles of the social model remain unchallenged - that the disabled individual should have maximum control over their own life, and that the goals are for independent living and inclusion to be accepted in the mainstream. It is clear that direct payments have a key role to play in putting those principles into practice.

6. Further Reading.

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- WHO (2001) International Classification of Functioning, disability and health, Geneva.

7. Further Information.

UPDATE, Scotland's National Disability Information Service.

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