

CHAPTER 1

Changing Disability Policies in Britain

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Introduction

The reforms in social policy associated with the establishment of the welfare state in Britain during the 1940s contained a number of initiatives designed to improve the lives of disabled people. However, the lack of meaningful progress towards social inclusion was highlighted, particularly from the 1970s, by an increasing number of campaigns by newly organised groups of disabled people. Their grievances ranged widely: against continuing forcible institutionalisation, segregation in 'special needs' services, higher rates of poverty and unemployment, lower educational qualifications, and the greater restrictions on leisure and social relationships compared with the rest of the population.

Disabled activists also developed a radical critique of the dominant 'personal tragedy' approach to 'disability' that characterised policy and service provision, as well as public attitudes generally. This regarded the person with an impairment as a 'victim' of their functional limitations and accorded policy priority to individual, medical treatment and rehabilitation, and state social welfare benefits. This also presumed a more general dependence on informal care provided by family and friends, together with the voluntary sector and charities. In contrast, disabled activists and emerging organisations of (that is, controlled by) disabled people advanced a social interpretation (model) that stressed the 'disabling' and exclusionary character of contemporary society (UPIAS 1976; Finkelstein 1980; Oliver 1983; Barnes 1991). This required policy action to overcome these barriers to social inclusion and to provide support for disabled people to lead 'ordinary lives'.

In this chapter, we will trace the recent growth of disability policies, with particular attention to the last decade. Our general conclusion is that, while there have been improvements in disabled people's everyday lives, and new opportunities to challenge their social exclusion, this remains substantial and wide-ranging. Too often, reforms have lacked

ambition and resources, and not been appropriately directed at exclusionary barriers. Hence, the continuing relevance of exploring a social model approach to disability theory and policy practice.

The emergence of the modern welfare state

Following the experiences of economic depression in the 1930s and the Second World War, a 'post-war settlement' between capital and labour led to wide-ranging social policy reforms. In developing a blueprint for this welfare state, Beveridge (1942) targeted the elimination of the 'five giants'

– want, disease, ignorance, squalor and idleness. In return, the state would pursue a policy of full employment as well as comprehensive social and welfare reforms. These included: the development of: the National Health Service (NHS); universal and free primary and secondary education; compulsory insurance contributions for all employees and the self-employed to cover for unemployment, and old age, together with various noncontributory benefits; family and child care support; and an expansion in council house building. However, there was also continued reliance on informal 'care' and support from family and friends, and a still active voluntary and charity sector.

These reforms represented a compromise between three overlapping 'welfare settlements': political-economic; social; and organisational (Clarke and Newman 1997: 1-8). At the 'political-economic' level, Keynesian macro-economic policies were at the heart of government thinking. These centred on a commitment to full employment that proved crucial in winning agreement for, and maintaining through National Insurance contributions, the welfare reforms. This national pooling of risk underpinned the political and ideological bases of the welfare state. It became the litmus test of a civilised society: where citizenship determined support for basic social needs (Marshall 1950). In practice, it offered a compromise between 'market-driven' (that is, through labour market participation) and 'state-guaranteed citizenship' (Clarke and Newman 1997: 1).

The 'social settlement' incorporated specific notions about the family and work that presume the 'norm' of a household headed by a wage-earning male providing for the rest of the household. Similarly, those with an accredited impairment were viewed as reliant on the family and friends. This view of disabled people as in need of 'care and attention' was regarded as 'natural', and was also used to justify state regulation of their lives (Barnes, Mercer and Shakespeare 1999).

The 'organisational' settlement comprised 'a commitment to two modes of co-ordination: bureaucratic administration and professionalism' (Clarke and Newman 1997: 4-8). Public service norms and values complemented claims that the new system would be impartial in its dealings with different sections and interests in the population. Similarly, the claim to expertise and neutrality in identifying and 'treating' social problems provided the rationale for professional control of service delivery. This was most evident in the influence of the medical profession within the National Health Service (NHS), but was also apparent in the role of professionals in education and, to a lesser extent, personal social services, something that attracted increasing criticism from social scientists (Wilding 1982). In addition, disability activists highlighted the unacceptable authority exercised by the 'caring professions' in their lives and the perception of disabled people as a dependent group with 'special needs' (Barnes 1991).

Disability and social policy: separate paths?

In the immediate post-1945 years, state policy on disability largely comprised specialised, segregated institutions, such as 'special education' schools, long-stay asylums and hospitals, and diverse residential accommodation (Humphries and Gordon 1992). The increase in the number of disabled people following the 1939-1945 War, and a heightened social obligation to 'do something' for them, triggered specific policy responses to address the problems facing disabled people. These included the Disabled Persons (Employment) Act 1944, as well as provisions within the Education Act 1944, plus the National Health Service Act 1946, and the 1948 National Assistance Act.

The Disabled Persons (Employment) Act 1944 was the first piece of legislation to extend the focus from specific impairment groups to consider disabled people in general. It sought to enhance their participation in paid work, while setting up a variety of 'rehabilitation' services and vocational training courses. It introduced the notion of reserved occupations for disabled workers, an employment quota scheme compelling all employers with more than 20 employees to employ disabled people, established the employment resettlement service and set up a nation-wide network of sheltered workshops. However, its implementation was not vigorously pursued and little effort was made to penalise employers who failed to satisfy the recruitment target. Similarly, the 1944 Education Act promoted the education of disabled children alongside their non-disabled peers in primary and secondary schools, although it allowed that integration was conditional on adequate tuition and funding (Tomlinson 1982). As a result, the

legislation encouraged the establishment of a system of segregated special education rooted in medical impairment categories.

Not surprisingly, the National Health Service Act 1946 reinforced the view of 'disability' as a medical (rehabilitation) issue. While long-term services and medical aids to enable disabled people to live at home were highlighted, funding resources were concentrated on acute care and services. The 1946 National Insurance (Industrial Injuries) Act continued the division of disabled people according to the source of their impairment, in providing benefits for injury, disablement or death caused by workplace accidents, but with liability transferred from the employer to the state. The 1948 National Assistance Act repealed the old Poor Law and mandated local authorities to provide residential and other services for anyone 'substantially handicapped by illness, injury or cognitive deformity', and maintain a register of those in receipt of services (but not assess wider support needs). However, little funding was allocated to expand non-residential services for disabled people. Instead, there were more significant moves to allow local authorities to delegate services to approved voluntary/charitable agencies. One outcome was the establishment of the Leonard Cheshire Homes in 1948 that subsequently became the largest single voluntary provider of residential accommodation for people with physical impairments in the UK (Drake 1999).

This legislation built the foundations for statutory provision for disabled people in the second half of the twentieth century. In practice, it sowed the seeds of a 'life apart' with separate/segregated and minimal provision, and their continued exclusion from the key institutions and processes of mainstream society (Humphries and Gordon 1992).

Seeking a 'community' solution

The emergence of protest action by groups of disabled people was initially concentrated on those incarcerated on long-stay institutions. This ran parallel to academic studies that highlighted the failure of institutional regimes to satisfy the emotional, social or physical needs of residents (Goffman 1961; Townsend 1967). The growing outrage was fuelled by a series of scandals involving the negligence and abuse of inmates which were externally confirmed in a succession of government-sponsored inquiries (Martin 1985).

The government decided to shift the policy focus to 'care in the community' having been persuaded that these offered an irresistible combination of better quality and cheaper services than institutional

alternatives. Even so, as it subsequently acknowledged, the calculation of economic benefits did not take into account the contribution of unpaid informal 'carers', or the inadequate level of community provision (DHSS 1981). In 1961, it was announced that the number of beds in long-stay, segregated hospitals would be halved. Subsequent plans for community-based services included sheltered housing schemes and workshops, with the 'mentally disordered' and the 'physically handicapped' identified as key priority groups (Jones *et al.* 1983). However, there was no comparable increase in resources for non-hospital services.

The Government also introduced changes in local social service provision in The Local Authority Act 1970 and The Chronically Sick and Disabled Persons Act (CSDA) 1970. The latter was promoted as a 'Charter for the Disabled' (Topliss and Gould 1982). For example, Section 2 covered local authority services for disabled people, including practical assistance in the home, help with recreational activities, and aids and adaptations in the home. The CSDA also instructed local authorities to provide for the housing needs of disabled people (Section 3); and access to public buildings (Section 4), including 'University and school buildings' (Section 8). In practice, the main developments were in areas such as residential and day centre facilities, respite care, meals on wheels, aids and adaptations, with most emphasis placed on the role of social workers, occupational therapists and physiotherapists. However, the now familiar caveat that services should be provided only if local authorities deemed it 'both practicable and reasonable' supplied an easy justification for inaction. As a result, local authority services were widely criticised as inadequate to bring about a significant improvement in the quality of disabled people's lives.

Restructuring the welfare state

In the mid-1970s a global economic crisis heralded a 'new right' (or 'neoliberal') critique of an interventionist welfare state and its 'excessive' expenditure on the grounds that it was more likely to create than resolve economic and social problems. In 1979, the newly elected Conservative Government, headed by Margaret Thatcher, outlined a programme designed to 'roll-back' and restructure the state, notably by introducing market competition into the delivery of welfare services in order to promote their efficiency and effectiveness. The broad political consensus around Keynesian macro-economic policies, full employment and widening social citizenship were overturned, while 'managerialism' was embraced as a strategy to increase efficiency and reduce the stultifying power of entrenched bureaucratic-professional interests (Pollit 1993; Clarke and Newman 1997). The policy shift was outlined in major

reviews of social policy, and specifically health and social care, in the 1980s (Griffiths 1988). These underscored the National Health Service and Community Care Act 1990 that provided a quasi-market framework, with greater involvement of the private and voluntary sectors, and gave an important stimulus to managerialism in public sector services with its introduction of centralised targets and performance measurement.

From a very different direction, social constituencies sidelined in the birth of the welfare state, including women, minority ethnic groups and disabled people, campaigned against their exclusion from mainstream policies. These attacks represented an unravelling of the 'settlement' between capital and labour that underscored welfare state legislation in the 1940s. Through the 1970s, there was a noteworthy growth in the politicisation and organisation of disabled people, with a growing number of disabled people looking to translate the social model of disability into practical action (Davis 1990). This was reinforced by abundant evidence from government surveys that disabled people still languished at the bottom of the social hierarchy, with disabling structures and processes resistant to state attempts at improvement, and effectively remained 'second-class' citizens (Martin and White 1988; Martin, White and Meltzer 1989; Grundy et al. 1999).

Rather paradoxically, the neo-conservative critique of the welfare state, with its emphasis on market competition (and citizenship), and encouragement of individualism opened up new possibilities for disability politics. A number of new disability policy strands can be identified. The stress placed on user involvement, evident generally in the proliferation of Consumer Charters, was enacted more specifically in the Disabled Persons (Services, Consultation and Representation) Act 1986. There was also slow recognition of disabled people's campaigns for appropriate support to live 'independently' in the community. In England and Wales, the 1948 Social Security Act had made it illegal for local authorities to make cash payments in lieu of services to disabled people in order to purchase their own personal assistance. However, in the 1980s and 1990s a few authorities were persuaded by local groups of disabled people to administer payments indirectly, that is, through a third party (typically a voluntary group or independent trust) (Zarb and Nadash 1994). A separate but linked development led to the establishment of the Independent Living Fund in 1988 to provide cash payments to disabled people. This was viewed as a temporary measure but proved as extremely popular with disabled people who saw an opportunity to achieve more choices and control of their lives (Morris 1993). By the mid-1990s, the Conservative Government were finally

persuaded that cash payments fitted with its agenda to promote market competition and individual choice in welfare by passing the Direct Payments Act 1996.

The period since the 1980s also witnessed concerted campaigns by disabled people's organisations (internationally and in Britain) for antidiscrimination legislation. This finally led to the passage of the Disability Discrimination Act (DDA) in 1995. While the DDA failed to satisfy disabled people's ambitions, attracting criticism for being located in a medical approach to disability, as too limited in its scope, and for allowing 'justifiable discrimination', it opened up new possibilities in disability politics. This was reinforced by the increasing adoption of a human rights perspective (Sayce 2000), with early interventions by the United Nations and more recently, from the European Union (Doyle 1999).

New Labour's strategy for disability policy

The New Labour Government elected in 1997 stressed its inclusionary goals by targeting low-income and socially disadvantaged groups in general, while also targeting measures at disabled people. New Labour gave centre stage to its 'welfare-to-work' programme, with the philosophy of, 'work for those who can and security for those who cannot' (DSS 1998a). There was also a major emphasis on modernising and reforming the welfare state, with an emphasis on applying private sector methods and providers, particularly performance outcome measures, for example, with league tables for hospitals, schools, and social services. Even so, New Labour retained many of the previous Conservative administration's economic policies including control on public spending until 2001.

In respect of disability, the Disability Rights Commission (DRC) was founded in 2000 to bolster the implementation of the DDA (although there are currently moves to merge the DRC with its equivalents for 'race' and sex discrimination into a general equality organisation). Interestingly, the DDA has been used rather more intensively than previous equal opportunities legislation, while the initial focus on employment cases has concentrated more on dismissal and unfair treatment rather than recruitment (Meager et al. 1999). The passage of the Special Educational Needs and Disability Act (SENDA) in 2001 extended the Disability Discrimination Act 1995 to cover schools, further and higher educational institutions. This means that it is now illegal to treat a disabled student less favourably (without justification) as a result of their impairment, or to fail to make 'reasonable adjustments' to include

them, such as physical features, auxiliary aids and services. If education was central to social inclusion then disabled children's experience required urgent action: in the late 1990s, 45 per cent of disabled children (16-29 year olds) left without educational qualifications compared with 13 per cent of the whole age group. Segregated education has been widely criticised for this shortfall.

The remit of the DDA also covered housing, transport, and the built environment. Additional employment rights, and rights of access to businesses and organisations providing services will become law in October 2004. Whatever improvements in social inclusion can be attributed to the DDA, there was also considerable scope for bolstering policy intervention to promote social inclusion.

New Labour also became an enthusiastic advocate of direct payments in lieu of services for disabled people. It expanded the eligibility criteria to include older and younger disabled people, people with learning difficulties, and carers. Moreover, their relatively slow and uneven development across the country led to the decision in 2002 to make it mandatory for local authorities to offer the direct payments option to disabled people. Its social inclusion agenda was further illustrated by a new strategy for people with learning difficulties outlined in the Department of Health White Paper *Valuing People* (DoH 2001). It presaged a shift from a 'medical' to a 'social' model approach, with an emphasis on 'Rights, Independence, Choice and Inclusion' (DoH 2001: 23).

Apart from cash payments, including direct payments and those offered to people on low incomes through the Social Fund (since 1988), personal social services operate as a key facilitator of social inclusion. They are overseen by a system of national and local inspection and evaluation, expanded by New Labour, including the Social Services Inspectorate, the Care Standards Commission, and the General Social Care Council.

Social services are central to supporting independent living for older disabled people, from washing and dressing, meals, social activities, and supporting 'informal carers' financially and with breaks, although unpaid care remains crucial for so many older disabled people. Nevertheless, personal social services have received much lower increases in funding since New Labour came to power than the NHS (DoH 2002). Government policy has moved towards focusing resources on those in most need, and charging 'clients' for services as a way of generating

more revenue. This places heightened pressure on informal 'carers' and the voluntary sector, and leads to greater social isolation and more institutionalisation of older disabled people. In a rare instance of devolution affecting social policy, the Scottish devolved Parliament decided to make all personal 'care' free at the point of use.

Welfare-to-Work

As an illustration of New Labour disability policy, its 'welfare-to-work' programme has probably become the pre-eminent example. Given disabled people's low levels of economic activity – 31 per cent compared with 77 per cent for non-disabled people (Labour Force Survey 1997) – and the much higher reliance on social security benefits, they were an obvious target for policy action. New Labour's welfare-to-work initiative sought to move people off benefits into paid employment, and improve job retention (such as when they experienced sickness), and reduce the reliance on 'sheltered' employment. It included the introduction of a New Deal for Disabled People (NDDP) in 1997: a package of schemes that often entailed partnerships between the public, private and voluntary sectors. Additionally, disabled people were one of the potential beneficiaries of the introduction of the National Minimum Wage (NMW) in April 1999, because of their over-representation in low-paid jobs. However, there were concerns that some groups, such as people with learning difficulties, would lose out because employers thought them less productive.

After its re-election in 2001, the Labour Government established a new Department for Work and Pensions, along with Jobcentre Plus by amalgamating the Employment Service and parts of the Benefits Agency (Burchardt 2003). Yet despite recognition of the wider barriers facing disabled people in the paid labour market (DWP 2002), welfare-to-work policies relied overwhelmingly on a supply-side approach to assist claimants become more 'attractive' to employers. Particular emphasis was placed on the unemployed person's motivation and capabilities and adapting to changing labour market demands. These were supplemented by: subsidies to employers recruiting unemployed people (re-training, direct wage subsidies, reduced payroll taxes); training unemployed people in new skills; giving unemployed people work experience; and providing improved job search assistance. In contrast, apart from the NMW, demand-side policies to generate jobs and economic development were far less prominent (see Chapter Two).

Yet while New Labour's 'welfare contract' called for a 'life of dignity and security' (DSS 1998: 80) it was less certain about how this applied

to those who cannot expect to work. Total expenditure on benefits for 'sick and disabled people' has trebled since the late 1970s and now accounts for one-quarter of social security spending. Contributory factors include widening eligibility, increasing take-up, a growing impact of extra-cost benefits, and an increase in the prevalence of impairment, notably with an ageing population. Hence, disabled people remain disproportionately reliant on social security benefits for all or part of their incomes, with two fifths of disabled people of working age on incomes below half the national average (Burchardt 2000).

The balance of the social system inherited by New Labour was shifted to stimulate entry into the labour market, although in order to qualify for welfare benefits, the disabled person still has to stress their incapacity for work. A particular government concern was that the social security system acted as a disincentive to seeking employment, as demonstrated by the more 'generous' level of Incapacity Benefit (IB) compared to Unemployment Benefit. This commitment to 'make work pay' underscored the main provisions of the Welfare Reform and Pensions Act 1999, and the replacement of the Disability Working Allowance (DWA) by the Disabled Person's Tax Credit in the same year. In addition, moves were made to integrate employment, social security, and taxation measures, along with organisational restructuring, to simplify the provision of benefits and support services, such as the merger of Benefits Agency, Employment Service and local authorities in a 'one-stop shop'.

The consequences for disabled people have been uneven (Powell 2002). Employment rates have risen since 1997, for both men and women, faster than for the non-disabled population (Burchardt 2000). Yet there were still many disabled people who had considerable difficulty obtaining appropriate paid work. Barriers, such as inaccessible workplaces, transport to work, and discriminatory attitudes and practices by employers and discrimination from other employees, proved resistant to change. Again, social security changes had a differential impact on the disabled population, with more targeting of benefits at those deemed in most need, with greater means testing and controls on unemployed disabled people.

This overview of disability policy largely ignores the possible impact of economic globalisation on welfare regimes, as well as important international initiatives, notably from the United Nations and the World Health Organization, to 'standardise' approaches to disability. Similarly, British membership of the European Union has stimulated its own

'external' influences on social policy, as with the projected harmonization of social security. However, broad objectives have not yet been translated into specific policies. Equally, the moves toward devolution within the UK since 1999 have opened up new possibilities for contrasts in social policy between Scotland, Wales, Northern Ireland and England.

Outline of chapters

The contributions to this collection demonstrate how the disability studies literature increasingly reflects the theoretical diversity evident in the social sciences. In early British debates on the social model, there was an obvious influence of conflict and neo-Marxist approaches (UPIAS 1976; Oliver 1983; Abberley 1987). Subsequently, feminist and interpretative influences grew in significance, while most recently 'post-modernism' and 'poststructuralism' have gained prominence (Corker and Shakespeare 2002). This has obvious implications for debates about disability and implementing the social model.

In Chapter 2, Alan Roulstone reviews the range of policy initiatives designed to further enhance disabled peoples' employment opportunities since 1944, with particular emphasis on the impact of the Disability Discrimination Act and the New Labour Government's emphasis on a 'welfare to work' strategy. He concludes that the overall impact in reducing the levels of unemployment, under-employment and wider social disadvantage has been very limited. A major weakness has been the lack of engagement with disabled people in developing effective policies to confront, for example, the wide-ranging barriers to paid employment, the professionally-led nature of services, and the nature of work in an 'inclusive' society.

In Chapter 3, Grant Carson and John Spiers examine the introduction of an innovative labour market employment and training project for unemployed disabled people based at the Centre for Independent Living in Glasgow. The authors trace the experiences of the first cohort of disabled people who moved into temporary paid employment in the housing sector (where they were able to explore suitable housing options for disabled people). The project identified key issues in supporting disabled people in these placements, including training plans, clarifying organisational expectations and possible changes. Overall, the success of this cohort in moving into full-time employment or further training highlighted the potential of such initiatives.

In Chapter 4, Malcolm Harrison critically examines the influence of 'environmental determinism' in writings on housing – notably

assumptions about the impact of the physical qualities of dwellings and the immediate neighbourhood on behaviour, health, and overall well-being. This approach overlaps with social model accounts that regard inaccessible buildings and spaces as a major source of 'disability', reinforced by wider financial and management constraints. Harrison argues that housing and disability researchers, just as much as policy makers and architect-designers must be careful not to over-emphasise the potential of technical solutions or consider housing and physical planning in isolation or separate from the wider social context.

Three chapters then deliver a wide-ranging review of the higher education (HE) system with detailed evidence of experiences in England, Scotland, and Wales. In Chapter 5, Paul Brown and Anne Simpson explore the relative impact of social model thinking compared with the medical or individual approach to disability on HE policy in Scotland. They argue that economic factors have a determining importance in driving institutional change, as is illustrated by their analysis of the general arrangements through which institutions are responsible to funding councils, and the larger political agendas that these arrangements represent. In their examination of HE provision for disabled students, there seems little coherent direction, although insofar as financial arrangements and rewards hold sway, they conclude that the medical approach still exercises the central influence.

In Chapter 6, Sheila Riddell, Teresa Tinklin and Alastair Wilson report on their investigation of disabled students in higher education in Scotland and England. They explore contrasting approaches to disability as a unitary category, and as a subjective, complex and multi-dimensional identity in researching access into, and the experience of, higher education. This involved quantitative data analysis of patterns of participation in higher education along with a qualitative investigation of the ways in which students negotiated their position by deploying a range of cultural identities. The authors indicate that impairment and disability are major factors in students' lives, but not always the determining aspects.

The enactment of the Special Educational Needs and Disability Act 2001 has forced higher educational institutions to re-think their policies and practices towards disabled students. In Chapter 7, Karen Beauchamp-Pryor reviews recent developments in Wales. She contends that disabled people have had relatively little influence on the design and implementation of HE policies, compared to major charities and professional bodies. The Welsh Assembly has acknowledged the

barriers confronting disabled people, but has not taken effective action to promote their social inclusion. Instead, a medical model approach remains dominant, with the potential of a social model interpretation to bring about radical change as yet unrealised.

In Chapter 8, Jennifer Harris discusses a central aspect of current social care practice: the assessment of need for 'community care' services. She explores a specific attempt to shift towards an outcomes approach that incorporates key elements of the social model of disability in routine assessment and review documentation. In exploring its implementation as part of a research and development project, she highlights the problems experienced by many professionals in moving towards a framework that emphasises user-defined aspirations and was perceived as encouraging increased managerial intervention. In contrast, service users welcomed the greater accountability and personal control afforded by this outcomes approach to assessment.

In Chapter 9, Charlotte Pearson, reviews the growth in direct payments to disabled service users to organise their own personal assistance. She highlights the relatively slower progress in Scotland compared with England. This is explained in terms of the greater resistance in Scotland to the marketisation of social care among local authorities, and the lower focus of disability activism on securing direct payments. Moreover, while the numbers of direct payments users are increasing, levels of funding and other support remain uncertain. Policy makers have to be convinced that direct payments are part of a wider demand for social justice and the right to independent living.

In Chapter 10, Dave Gibbs criticises the notion of 'social model services'. Drawing on his experience of working with the Derbyshire Coalition of Inclusive Living (DCIL), he argues that it must be more than a service provider and that the people DCIL supports are not simply passive 'users'. Instead, DCIL service programmes overlap with its other functions, such as lobbying and campaigning. Moreover, while public services for disabled people have effectively acted as a means of control, DCIL provides general support for inclusive living. Hence, the political goal is to redefine public services by drawing on an applied social understanding of disability, rather than pursuing separate 'social model services'.

Debby Phillips in Chapter 11 explores the impact of professional health and social care systems in the daily lives of women labelled as having learning difficulties. She explores the power dynamics evident in

the 'carer/cared-for' relationship. Many of her research participants criticised the involvement of health and welfare professionals in their lives and dismissed suggestions that these took the form of a partnership. Nevertheless, there was some evidence of alliances with female support staff, such as in non-medicalised, alternative health practices. Yet, overall, professionals failed to recognise the importance to people with learning difficulties of life style adjustments, periods of transition, and issues concerning parenting and sexuality.

In Chapter 12, Dan Goodley also illustrates aspects of the professional domination of the lives of people with the label learning difficulties. He suggests that enabling theory, practice, and politics can gain considerably by turning to narrative and discourse analysis rooted in post-structuralism. This entails turning the analytical spotlight on people's narrative accounts: particularly, how education constructs and regulates the person with 'learning difficulties'. A priority is to scrutinize social exclusion in terms of institutional practices and discourses. These value, promulgate, and divide access to knowledge in historically specific ways. Additionally, the achievement of diverse forms of resistance by people with learning difficulties must be recognised.

In Chapter 13, Gerry Zarb examines the significance of independent living to social inclusion, and its links with the social model of disability. He explores independent living as a civil and human rights issue, illustrated by interventions from the Disability Rights Commission. He expresses reservations about the efficacy of anti-discrimination legislation, and acknowledges concerns that individual rights solutions may clash with a social model approach which stresses the collective emancipation of disabled people. As the continuing significance of exclusion, institutionalisation and segregation demonstrates, much needs to be done to win the argument about the merits of independent living, and its status as a universal human right.

Review

This chapter provides a broad overview of the development of disability policy starting with the legislative foundations of the welfare state established in 1940s. This is set within more recent efforts to 'roll back' and restructure the welfare state, as well as the broader struggles by groups of disabled people for more equal opportunities for inclusive living. Criticism that the welfare state in general and disability policy in particular has 'failed disabled people' is based on wide-ranging evidence of continued social exclusion. It remains a 'fact of life' for disabled people, who are denied the same opportunities to lead 'ordinary' lives

that non-disabled people take for granted.

The contributors to this collection provide detailed case studies in many different areas of social policy and social life that illustrate the disabling barriers and attitudes remain very resistant to policy reforms, although changes are taking place. They also demonstrate some of the competing interpretations of the social model approach, as well as ways in which it can be applied in order to inform radical policy action.

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