CHAPTER 10

Social Model Services: an oxymoron?

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Changing fortunes of social model praxis

This chapter examines the application of a social understanding of disability to the development of practical supports for disabled people's goals – the job of a Centre/Coalition for Independent/Inclusive Living (CIL). It provides a brief 'status report' on a programme that has been underway for twenty years at one CIL, in Derbyshire (where we are a 'Coalition for Inclusive Living', but the name variations need not concern us here), then looks at obstacles to their further development and to effective extension into the mainstream of public services.

   The usual language of a CIL's work is one of the refinement of models by a process of practical application, rather than of theory. Opportunities like this seminar series, however, encourage a brief detachment in which to examine issues that underlie daily concerns. The ones I will focus on here are primarily issues of *relationships* – those between ourselves, as a development unit working to a mandate from disabled people, and the authorities that implement statutes and deliver mainstream services.

   Concerns about these relationships are not new. The capacity to work together in a strategic way, as was possible in Derbyshire CIL's (DCIL) early years, was effectively lost more than ten years ago. Profound changes of relationship between central and local government and the voluntary/ community sector went along with the intense centralised control needed to introduce 'internal markets' in public services. More recent changes stress an increased role for voluntary and community organisations, but for all the emphasis on their 'added value' the role envisaged is as auxiliary service providers within an essentially hierarchical structure. A core role of grassroots innovation, which may go on as much as a generation ahead of anything operating within that structure, is likely to remain in jeopardy.

   Others have offered pointers on ways to understand these changes in

examining another relationship – that between the academic discipline of 'disability studies' and the disabled people's movement (Barnes et al. 2003). After noting effects on this relationship of 'the increasing marketisation of academic life', the authors distinguish three approaches applicable to the relationship. These are: an 'inside out' approach giving primacy to direct experience (as in a general statement that 'personal is political'); an 'outside in' approach led by analysis ('political is personal', if you like); and an 'outside out' approach embodied in the reductive mode of thought which dominated the modern era and still goes unchallenged much of the time.

In my understanding of how our work as a CIL has developed, there has been a 'phasing' of the first two approaches. It might be expressed simply as: model + praxis = theory. For this to become a fully developed alternative to reductive thinking, we will need to add an 'inside in' approach too. This will be a 'whole systems' one focused on connections rather than on a reduced state of things connected. Wide applications of this thinking began to be introduced by writers like Bateson (1972), but we can recognise it in a basic form in the original framework that disabled people put forward for a CIL – the 'Seven Needs' (Davis 1990).

Statutory authorities are, by and large, 'outside out' entities: the way they have conducted their relationships is highly reductive. I have noted elsewhere (Gibbs 1999) that applied social sciences have held on to this thinking long after the 'hard' sciences have begun moving away from it. Here I want to go further and identify specific traits – underlying *errors of thought* – that may account for what I believe is a permanent failure in the theoretical base of 'social care' services. Then I will try to come forward with more 'connected' alternatives by which social model praxis may gain the mainstream.

A status report
There is no consistent format for those organisations of disabled people variously called Centres or Coalitions for Independent/ Integrated/ Inclusive Living. In response to local circumstances, something with the essentials of a CIL can be produced by several different routes:

- one that starts with a core service and adds on others;
- one where several existing services are brought together under a new management structure;
- one where a range of services and projects are managed in a loose association;
- one where a range of closely linked projects are set up from the

start.

A recent study (Morgan et al. 2000) found no distinct boundary for what might be defined as or define itself as a CIL. My own list of essential features would be:

1. an underlying principle of peer support, in which disabled people come together and support each other;
2. disabled people's control on the governing body;
3. an applied social understanding of disability; and
4. an integrated approach to support needs, recognising that a social model cannot be applied by services that meet needs in isolation.

This is enough background for a brief review of the current status of the main activities in an early organisation of disabled people such as Derbyshire CIL (DCIL) that has its origins in the fourth mode listed above.

Information
The network of Disablement Information & Advice Lines (DIALs) began as a handful of local peer-support lines set up by disabled people in the late 70s. A national body to promote the network, DIAL UK, was formed early on and has done much to set standards for a professionalized service. DIAL-Derbyshire was absorbed into DCIL as its Information Section. Despite 26 years continuity as a service developed by disabled people, it remains essentially a development project: ultimately, the goal is for mainstream public information services to be fully inclusive.

Peer counselling
Disabled people began to qualify as counsellors in the mid 1980s. Defining support that was about developing confidence, rather than 'coming to terms with disability', and was not easy to begin with in terms of standards set by established counselling associations. More recently some affinity of approach has been recognised with the highly effective 'MindFields' courses associated with the European Therapy Studies Institute. This has helped to support the counselling team's interest in strengthening the professional basis of their service.

Independent living advice
In 1995 DCIL contracted with the Social Services department as a 'community care provider'. The context of this development, and the issues of resolving different approaches, are fully analysed by Priestley (1999). Even after the difficulties were overcome, this contract on its own

was an insufficient arrangement to deliver outcomes of independence, but it was linked with a National Lottery funded development project. This project both employed disabled people as 'integrated living advisers' (giving status to what had been a voluntary peer support role) and began an 'education programme' by which a qualification at NVQ Level IV would be developed for this role. A local organisation lacks the infrastructure to market and deliver such a programme on its own, but when that structure is in place it will be an important adjunct to 'disability equality training' as a means to professionalize training developed from peer support.

Mentoring

When independent living arrangements are secure and under the disabled person's control, possibilities open up to go on to community participation in a fuller sense. The principle of peer support, by which people pass on their experience, can be extended to any of the transitions during the life-course, where added obstacles are in the way of disabled people. Ways are being found to train disabled people as mentors in transitions like those from 'special schools' to adulthood, from 'day care' to community alternatives, and from 'welfare' to training and employment opportunities.

Community development

Support to individuals has to be matched by improved access in communities, to meet changing expectations of a full active role. Community development functions can add value by networking in many ways, but problems in getting sustained resources for this arise because its benefits have been difficult to measure. Simple measures DCIL has used, however, touch on fields that are developing rapidly. Estimates we have made of economic impacts at a District level anticipate ways economists are beginning to evaluate social welfare (Sefton 2000). Simple 'quality circles' to evaluate change in progress apply 'theory of change', and member participation programmes develop 'social capital'. Consolidating these connections will in time provide an evidence base to 'professionalize' community development functions.

Errors of thought in the provider-user relationship

In this section I want to distinguish the main barriers in thinking which, in my view, continue to defeat goals of the disabled people's movement and the effective application of a social understanding within mainstream services. They may be best thought of as residues from a culture of welfare paternalism, and are:

- an insistence on categorising people instead of issues and support needs;
- a management culture of control, assessment and prescription to which concepts like peer support and self-definition of outcomes are anathema;
- a relationship of 'helper and helped' which is locked into a mentality of 'us and them'.

Arising from these, and on another level, is an emergent culture of target-setting, measurement and monitoring which is dehumanising and contrary to human rights. Its detrimental effects on public services is being recognised (Audit Commission 2002), hopefully before it reaches a point where its stresses will implode and render existing models of public service unworkable.

For each of the three relics of welfare paternalism that create the obstacles, there is a well-defined train of new thinking that leads beyond them. These alternatives cannot be presented, I suggest, as any viable reforming programme, but only as an indivisible replacement model of support provision. I will try to describe and understand each of the obstacles, and then propose corresponding solutions.

Errors of categorisation
By errors of categorisation I mean a process in public administration by which attention to support needs and outcomes is continually distracted by a compulsion to classify people. It has two main expressions, which present great barriers to delivery of useful practical support: the 'silo mentality' – dividing people up for administrative purposes; a converse process of lumping people together, e.g. 'sick and disabled'.

Perhaps one of the best illustrations of the process is in attempts to measure 'quality of life'. This has entered the problematic setting of prioritising who receives support, and of course that has made it controversial. I think it only became problematic, though, because of distraction from its proper terms of reference. The first measures of 'quality of life' did not refer to people's personal characteristics at all; they referred to environments (Marks 1999: 38ff), that is, to:

- ☐ air – how free is a community's air from pollution;
- ☐ water – how much untainted water does a community have access to;
- ☐ then shelter, and an adequate varied diet;
- ☐ then freedom from conflict and persecution; and

then freedom to learn and apply learning, to gain independence and

earn a living, to raise a family – to make the natural transitions of a life's course.

By these criteria, you have a good quality of life if neither your environment nor your society fetters your development – if neither of them disable you, in other words. These environmental measures are obvious and can be understood by anyone, yet this does not prevent their diversion in various areas of health and public administration into preoccupation with quite bizarre farragoes of personal characteristics. The first stage in addressing barriers to employment, for example, is to sort people into categories like 'musculo-skeletal', 'respiratory' and 'mental'.

Errors of response
By errors of response I mean the system of assessment and prescription for 'social care' services. It contains several elements:

- a summary invalidation of an individual's own perceptions;
- a default to basic maintenance like home-care rather than outcome-based support, for example mentored transition;
- a confusion of short-term and long-term considerations.

Service 'modernisation' and the new training behind it are full of declaration and invocation with an appearance of addressing the worst effects of one or other part of this system. But as Finkelstein (1999:6) points out, in much of it '"assessment of needs" and "empowerment" have been abandoned in favour of verbiage'. What it lacks is overview and strategy, displaced or tokenised by hierarchical management structures in which 'users' views' are reduced to a part of what is to be managed. Words like 'empower' and 'enable' (even 're-able', which has entered the modernisation programme like a mystery virus) are used in a sense of something that can be prescribed. This usage must be flatly refuted: from the moment someone presumes to prescribe and manage another's 'empowerment' they prevent it; from the moment they ask 'how can I empower this person?' they begin to do the opposite.

Despite the key role of an assessment function in the training and role identity of many practitioners, large sectors of it have in fact come about by default. These are the countless means of 'gatekeeping' resources by some form of quasi-medical endorsement. Disabled people have had provision for their needs firmly under medical supervision throughout the

industrial era, so this medical model is very deeply bedded. Doctors are involved in all kinds of things that do not obviously call for medical qualifications: deciding if you can drive or where you should be educated; prescribing wheelchairs; requirement for personal assistance; measuring work capability; benefits entitlements. In earlier times, doctors' associations appear to have resisted having bureaucratic gate-keeping jobs off-loaded on to them – an interesting piece of history that I don't believe has been properly documented. Of course power, once handed over, is seductive and self-enhancing: new consultancies in Rehabilitation Medicine soon arose from systems to gate-keep supply of basic equipment.

Errors of perceived relationship

By errors of perceived relationship I mean a perception that difference between the provider and user of a service, which may be temporary and to do with stage of the life-course, is permanent and inherent. Put more simply, it tacitly assumes a distinction of 'us and them'.

This error is supported by a social theory that is primarily mechanistic and reductionist. Cause and effect explains the difference between 'us and them', and reductive analysis informs the interventions by us in the lives of them. I suggest that this method of thinking does not explain the division of 'us and them' but creates it. In an alternative view of the service relationship, we all occupy a matrix with multiple scales of empowerment in different life faculties, and we move up and down various scales at different times in our lives. Such a relationship is not amenable to reductive analysis, and methods of intervention that assume an unchanged 'us' can be an agent for changing 'them' so that they become part of the problem.

As with errors of response, this third kind is self-perpetuating. Once a system is in place that manipulates people to accept subsistence on the outer fringes of society, there is no clear demarcation from more drastic modes of exclusion – institutions, withholding of treatment, and ultimately assisted exit.

Where do the errors come from?

It is necessary to ask if what I am calling 'errors' are specific to a particular stage of transition from welfare paternalism, or if their social, cultural and political context extends more widely. If it is the latter, new analytical tools may need to be found in order to ground the search for alternatives. These tools might be sought in two quite different ways.

1   Historical. Both the beginning and end of the 'modern' era – the Enlightenment era of science – saw attempts to analyse the 'hard-wired' errors that thought is prone to. In the seventeenth century Francis Bacon defined his four 'idols of the mind'; early in the twentieth century Bertrand Russell in the 'Principia Mathematica' set out his highly formalised concept of 'logical typing'. Bacon's 'idols' are predispositions to perceive something in terms of reference to which it does not belong. The four he proposed grade from specific and personal (like assuming others perceive things in the way we do) to general and cultural (like those bedded in language or traits we put down to 'human nature'). Russell's system of 'logical typing' resides in the field of formal logic, and caution is needed to map it onto more day to day concerns. Its purpose is to keep thoughts that apply to a particular thing strictly separate from thoughts about any 'class' that the thing might belong to. I suggest that a formal error of logical typing has been made when certain kinds of individual difference are: a) seen apart from the rest of someone's personal equation, and b) made to define a class in which varied individuals are treated in homogenised ways. This error contributes to creating what I earlier called an 'error of perceived relationship'.

2

3   Global. The concept of social exclusion, along with its understanding and solutions, has rapidly extended in the last few years to a global setting as part of the complex debate on 'globalisation'. Analysis of the social injustice, waste and destruction associated with a dehumanised global economics led by uncontrolled finance networks (Capra 2002) suggests the same pattern on a different scale as the obsessive centralised control led by 'targets' which public services have been encouraged into by 'errors of thought' like those identified above. Equally, the coordination of regular actions against the World Trade Organisation from 1999 onwards has been by global networking of highly diverse interests. The voluntary and community sector may learn to respond to its own 'colonisation' in a broadly similar way.

A framework for solutions

In the above analysis of disabling obstacles in public service relationships, I have suggested they arise from structural 'errors' which are more 'hardwired' than may have been recognised. The introduction of alternatives, therefore, will be correspondingly difficult. It may not be enough to have a clear-sighted alternative model and pilot projects to demonstrate its practical applications. An 'outside out' mode of thinking, serving the interests of a hierarchical power base, can be countered only by one that is 'inside in' – an alternative system.

A framework robust enough for alternatives outlined below will provide safeguards against reductive ('outside out') modes of thought which 'objectify' people and their needs. It will be one that is systemic: that is to say, it will replace a disposition to see the world in terms of dualities – subject and object, observer and observed, producer and consumer – with a recognition of interrelations, feedback, and learning exchange. Diverse applications of systems thinking, advanced for example by Bateson (1972), have been taken up by writers like Midgley (2000), who follows systems thinking through from philosophy to the 'politics of social inclusion' and operational issues of interventions in community development work. At least one university based unit promotes applications of systems thinking primarily in health-related research (http://www.uwe.ac.uk/solar/index.htm).

An indivisible social model
In 2001, the World Health Organization (WHO) published the *International Classification of Functioning, Disability and Health* (ICF). This substantially revised its original *International Classification of Impairments, Disabilities and Handicaps* (WHO 1980). The ICF refers to a 'dialectic' of 'medical model' versus 'social model', and claims that its new classification is 'based on an integration of these two opposing models' (WHO 2001: 20). It withdraws the term 'handicap' as redundant while extensive sections on measures of 'participation' illustrate its acknowledgement of the social dimensions of both disability and health. The revision may appear at first to be a substantial step to adopting a social understanding, even moving towards what might be called a 'social model of health'. I would argue that, to the contrary, no progress can be based on its notion of 'integration'.

When reflecting on how the 'social model' might develop, it must be recognised how widely it continues to be subverted. Even social work practitioners now sometimes claim that their departments 'work to the social model'. The relics of welfare paternalism located in statute and in working practices mean that such claims rest on unacceptable distortions or, at best, admit only what I would call an 'individual' level of social model. In a fully integrated programme, however, two other levels are applied. A 'collective' level extends to broader issues of access to communities and to experience shared with other excluded groups. A further, 'historical', level identifies and challenges active processes of exclusion at their source. These goals are not addressed as a natural consequence of meeting needs at the individual level.

The impact of the social model has come from its clarity and simplicity,

which has two immediate effects:

- on the self-esteem of individual disabled people who see, gradually or by a dramatic change of awareness, that 'disability' is not in them but in their surroundings;
- in a switch to very direct practical solutions, after befogging complexities of classifications, assessments, pressure to 'come to terms with' the things that most need to change, and deferral of attention pending 'cure'.

In order to fully operationalise these impacts, however – to fully 'cash out' their benefits, maintain progress, and guard against distortion – a further point has to be recognised. For the social model to work, you have to buy in to the whole thing. The social model is a 'paradigm': its application shifts the whole framework in which something is thought about. Because the whole framework has shifted, it is no longer reducible
– parts of it cannot be combined with other models in a process of *bricolage* (or 'pick and mix').

There are several questions that might be asked to test this 'hard' interpretation of what the social model means. I would simply like to present them here for critics to scrutinise – whether activists, academics, or people with vested interests in different models altogether. A 'yes' to any question will mean the model is 'reducible' and can compromise with other models; the absence of 'yes' responses means our task is to develop the social model till it joins up with other new and unfamiliar ways of looking at the world.

The questions I would suggest are:

- Is there a 'percentage' angle – are there situations that only can be understood using, say, one part social model and two parts something else?
- Is there a 'point of view' angle – the social model works from one viewpoint on a given situation, but not from another?
- Are there 'intermediates' between social and individual models?
- Does the social model work on one level but not on another – for example between personal, social and historical points of reference?

'Professions Allied to the Community'
The idea of 'Professions Allied to the Community' comes from Vic Finkelstein, who set it in direct contrast with 'professions allied to

medicine'.

He expressed a view that: Centres for Integrated Living (CILs) are one structure created by disabled people to service (self-defined) aspirations and, in my view, workers in these centres are an embryonic PAC. This professionalisation process exactly replicates the progress made by women when they created their own midwifery service (Finkelstein 1999:6).

In my 'status report' earlier, I tried to give some sense of how far the various functions of one CIL have begun to 'professionalize'. Clearly, the process is still far off from what most people would think of as a 'profession' – a high status calling rooted in intensive training. I think it fair to say that professional training has become increasingly dominated by acquisition of technical skills and knowledge – a focus on learning about things rather than their connections and relationships. The new alignments of skills needed for PACs would need to include a corrective to this – a 'didactic framework', shall we call it – that has structured in to it safeguards against the errors we've identified and guidance towards the complementary new faculties.

In a recent article (Gibbs 2003) I made a very tentative sketch of some characteristics and content for this framework:

- It will be defined not only by its knowledge base but also by its purpose: to reverse long-term cycles of disempowerment.
- It follows that its theoretical base will be a developed historical understanding of destructive imbalances of power.
- It will be cross-cultural, because it must deny sustenance to aspects of a global economy that most threaten progress towards social equality and sustainability.
- It will combine personal support and community development skills. Coming to specific 'modules' that might be included, there might be on the personal support side:

- uses of information and systems of information,
- models developed from peer support,
- something from the pragmatic end of counselling theory, such as 'human givens' (Griffin and Tyrell 1999); and on the community development side:
- infrastructure of public service provision,
- purposive monitoring and audit of social capital,

- models of system intervention (Midgley 2000).

A life-course framework

Mark Priestley (2003) has recently examined aspects of disabled people's exclusion within a framework of the 'life course'. His aim was to explore the life-course as 'a useful analytical frame for understanding current disability debates', but it also may be useful as a strategic framework. When DCIL responded this year to local consultation about eligibility criteria for access to 'social care' services, we tried to apply that approach: the process may have taken us a little way towards proposals for practice that would guard against the third 'error'.

Problems in deciding eligibility include:

- A conflict between meeting basic maintenance needs of as many people as possible and the substantial support needed to establish independence, where this is the only appropriate outcome.
- An expectation that younger disabled people might be service consumers for 30-40 years, so are a resource 'problem' because most service use for the adult population as a whole falls within a few years late in life.
- A stress on preventing negative change may impair support for positive change. Review focuses on checking if provision can be reduced or withdrawn, rather than monitoring whether it is working or needs to change direction.

Proposed adjustments are:

- That focus on transition – as already applied in young disabled people's transition to adulthood – is extended to all other stages of the 'life course'.
- That the 'standard' support pattern becomes one of support at a stage of transition: transition from education; transition from family or institutional dependence; transition from illness or injury; transition to supported old age.
- That the overall model then becomes one of many people passing through supported periods, rather than a lot of people maintained at a subsistence level and a few supported to greater independence as resources allow.
- That standard working practice 'defaults' to focus on outcomes, and reverts to maintenance only by active choice. Effects would be:

- More people using services for shorter periods (as a stage towards a longer-term outcome where use of 'social care' services is fully integrated with use of any other kind of public service).
- A better chance to pass on from a first stage outcome (support with personal care and domestic needs is safe, secure, and under the user's effective control) to a second stage where support is with goal setting and possibilities of moving on in life.
- Linking with trends to multi-sector provision. Closely related supports towards employment, for example, may be found in public, voluntary/ community, and private sectors. The perceived aims and daily language of different sectors may differ widely, but partnership structures are needed to bring them together on common ground.

The key benefits of focus on transition are:

- It provides a common framework for different levels of intervention
  - acute health interventions, 'care' solutions, and support programmes in the voluntary/community sector.
- It minimises transfer of choice and control out of an individual's life-course to someone else.
- It puts service interventions in a context that everyone shares.
- It draws 'social care' interventions into a closer proximity to other public and private support interventions that a citizen calls in as and when required to supplement their own skills, such as a solicitor, architect, or plumber.

Mainstream applications?
The social policy context
It remains to link the analysis and proposals in this chapter to the wider social policy setting. Modernisation of public services is, of course, a very active area of social policy just now. For disabled people, however, this high level of activity is a source of some bewilderment. There seems so much opportunity to support full inclusion, yet so little specific strategy to bring it about. Two linked interpretations might be ventured:

- disability policy remains predominantly within a corral of 'health and social care';
- the high cost of maintaining this corral means that the cost constraints of disability policy always come before anything else.

Both the policy and those who must implement it, therefore, are in a classic 'double bind': 'we can't afford to help you out of the corral because it costs too much to keep you in the corral'.

One commentator on the wider policy context offers as explanation for recent Government conduct a dominance of neo-liberal over social democrat thinking at the policy centre (Hall 2003). This would certainly tend to make invisible any product of thought outside the fundamentalist dogma of 'market forces', but it seems so incredible that there could be such a degree of drift from social democratic origins that more specific evidence ought to be found.

The current Home Office incumbent, David Blunkett, has written rather more analytically than is usual for Ministers while in office. In *Politics and Progress* (Blunkett 2001) he sets out a vision for reviving 'excluded communities', but this takes a view of 'communities' which seems to leave apart issues relating to excluded constituencies. Specifically, disabled people's inclusion is conflated with what he calls the 'challenge of incapacity' – security for 'those who cannot work'. Neither here nor in other statements of policy thinking is there any clear separation between prevention of work by illness and by disabling obstacles placed in people's way by their environment. Certainly, there is no recognition that self-definition might be the way to make this separation, rather than some form of quasi-medical assessment. It has to be concluded that the kind of errors identified earlier extend from the policy centre, and have to be analysed on a similar basis. Solutions too would be of the same broad type: in this example, the concept of 'incapacity' should disappear, subsumed in a general policy of inclusion and support with transition.

Meantime, the chimerical co-existence of neo-liberalism and relic welfare paternalism would seem to provide a particularly toxic environment for disabled people's inclusion. Strung between defunct ideologies, the meaning of 'inclusion' may cease to relate to communities at all, but promise instead a corral for everyone within a single management hierarchy. With no 'third way' on offer beyond the even worse option of charitable 'trickle-down', there is one basic principle to fall back on: needs and solutions are defined within the excluded constituencies where they arise.

Social model services?
My title signals some wariness at the notion of social model services, and I should indicate why I think the line taken above makes it problematic. To use my organisation, DCIL, as an example: it is not to

be seen definitively as 'a service' because provision of a personal service is only one of the responses that might be required to meet a mandate from disabled people. The people it supports are not to be constructed as 'users', because such a role has constraints on what people might want to say about the purpose, direction and inclusiveness of public services. And it does not purport to 'involve users', because historically it's an organisation in which disabled people 'involved workers'.

Because the social model is non-reducible, it cannot be implemented by any programme of services that is separate from other functions. Even within the disabled people's movement, it is commonly believed that 'service provider' and 'lobbying' functions are incompatible in a single organisation. To the contrary, the social model cannot be applied by either on its own. The duality is false, and a social model is applied by a continuous series of responses, geared mainly to the degree of resistance mounted by established modes of working.

The word 'services', moreover, does not have the same meaning in relation to disabled people as 'public services' does in relation to the general population. To use the concept cited earlier, its reference is of a different logical type. 'Public services' are specific operations that support the social infrastructure, like transport, housing, and public recreation; disabled people's services are a class of operations that places additional controls on a sector of society. To admit disabled people to public services, the outcome of an applied social understanding of disability must be the disappearance of that class of operations. 'Social model services', then, is an oxymoron.

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