

## CHAPTER 8

### Incorporating the Social Model into Outcome-Focused Social Care Practice with Disabled People

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#### **Introduction**

Social care practice in the UK is routinely concerned with the identification of service users' 'needs' during social services assessments. Local Authorities have had a duty to carry out an assessment of need for community care services with people who appear to need them since the enactment of the NHS and Community Care Act 1990 (Section 47(1)). Previous to that they had duties of assessment of individual needs of everyone who fell within Section 29 of the National Assistance Act 1948 which were enacted through the provisions of the Chronically Sick and Disabled Persons Act 1970 (Section 2). It is asserted here that the focus upon 'needs' has become impractical at both the conceptual and practice levels in recent times.

This chapter begins with an exploration of this move away from the focus on the 'assessment of needs' and offers a more fruitful model of service philosophy. This is the outcomes approach (OCA) that has been used by the author in a research and development project within one local authority area in the UK. The outcome-focused approach is consistent with the spirit of these Acts but challenges the notions of expert power bound up in the framework of assessment in favour of one in which service users utilise the skills and experience of professionals in the identification and achievement of their desired outcomes.

The OCA discussed below incorporates key elements of the social model of disability into routine assessment and review documentation used every day by social care professionals working with disabled people. Social Service staff receive training in the OCA and the use of newly designed outcomes-focused documentation, which directs the professional to think laterally in assisting the service user to achieve their desired outcome. Thus for the OCA to work properly, the professional must act as a facilitator, as originally envisaged in the NHS

and Community Care Act 1990, rather than as a direct service provider or gate-keeper to services.

The project is funded by the Department of Health and is approximately half way through a three-year term. The chapter describes the commencement of the outcomes focus, initial findings concerning successes and problems in its introduction.

## **Background**

The research and development project described here forms the first attempt to change the focus of social care assessment and review from 'needs' to 'outcomes' within a Disability Service. The concept of 'outcomes' as operationalised within the project means that the focus of the work is upon the goals or desired achievements of the service user. The main thrust of direct work with service users for the professional becomes assisting in the identification of these goals (immediate, medium term and long term), and thereafter facilitating their achievement. These processes are documented using newly designed outcome-focused forms that direct and guide the professional in these tasks.

Prior to the innovation of the Outcomes Project, the Social Services department (in common with most other social services nationally) focused its work around the identification of service user 'needs'. There are a number of reasons why focusing upon 'needs' is problematic, both conceptually and practically. The identification of 'needs' is no mean feat, since theoretically these are subjective, potentially endless and relative to one's immediate situation. Direct work with service users is necessarily subjective, the focus being upon their immediate situation, and support requirements. However, to state that the focus of work should be the 'identification of needs' implies a level of objectivity that is rarely present. It also implies that the professional will be working in a 'diagnostic' capacity and contains inherent strict hierarchical implications concerning the relationship between professional and service user (French and Swain 2001: 735).

Focusing upon 'needs' is also problematic because peoples' needs change over time, (often quickly in crisis situations) and there is no specified point at which the work, or a distinct part of it, can be said to have been achieved. In consequence, the work frequently lacks direction and purpose. It is also therefore virtually impossible to know whether resources used have been correctly or fairly targeted. It is similarly almost impossible to measure success or failure.

Another problem with focusing on the identification of 'needs' is that work is structured around a moving goalpost, since once some needs are identified and achieved, there are almost certainly other needs to be met. This way of working engenders a situation where there is no distinct endpoint to the work between professional and service user and the date at which involvement with social services will end is unclear. This scenario leads to situations in which disabled people become 'service users', the point of the work is unspecific, it cannot be judged to have been achieved and involvement with professionals is open-ended over time. Work structured around needs therefore enforces and perpetuates dependency-creation (Oliver 1993; French and Swain 2001: 744). Furthermore, 'needs' are necessarily relative to a particular situation only and their resolution, and therefore the involvement with professionals, can only ever be partial.

### **Introducing the outcomes focus**

In the outcomes project, the challenge set was to change professional practice and documentation used, away from one in which the professional steers, guides, pronounces the identification of 'needs' and the proposed 'intervention', towards practice driven by the service user, who is encouraged and facilitated to identify their 'outcomes'; a set of immediate, medium and long term goals that they wish to achieve. The focus on outcomes overcomes many of the deficiencies of the 'needs' model described above.

Focusing on the service user's desired outcomes means the work is targeted and specific, with a distinct endpoint in mind. Review dates are set and closely monitored by the service user in terms of achievement of their outcomes. The focus of the work moves away from professional 'assessment of the service user's needs' to the identification and facilitation of desired outcomes, specified by the service user. When the outcomes focus works as it was designed therefore, the service user is in control of the entire process, from identification of outcomes, to participating in their achievement and evaluation of the success or failure of the venture. The role of the professional is to assist the service user in the achievement of their outcomes only. As discussed below, the latter implies a radical culture shift from existing practice.

The research team were concerned to adhere to the social model of disability (Oliver 1990; Barnes 1991) when designing the documentation (particularly in the use of language) and staff training with a view to steering professional practice towards a focus upon 'access' and away

from the traditional professional focus upon function and deficit. The new documents also contain a direction to utilise mainstream, instead of segregated, facilities.

The outcome-focused documents incorporated a framework, which was developed in consultation with all stakeholders and from previous research findings (Bamford et al. 1999). This original outcomes framework contained many core criteria that had been found to be of interest and use to disabled service users, but the language used in the framework was old-fashioned and paternalistic, more medical than social model with an acceptance of limitation, functionality and deficit. Our first task was to revise the framework therefore. The revised version of the outcomes framework, devised for the project, contains a much stronger focus on access to educational, training, employment and leisure opportunities, and also focuses upon supporting parenting. The outcomes framework that appears in the new documentation explicitly directs the professional to ascertain the situation as seen by the service user. The spirit of the social model is most evident in the user control aspects of the design and designation of professionals as facilitators/assistants within the identification of outcomes process.

Experience in this kind of research has shown that one of the best ways of influencing professional practice in particular ways is to design documentation incorporating the innovation and train professionals in its usage. However, it has also been noted that professionals sometimes struggle with the concept of outcomes and their professional and organisational culture militates against introduction of such innovations (Qureshi et al. 1998). Previous research and development work conducted as part of the wider outcomes programme suggested that, once staff have a clear understanding of the outcomes concept, the outcomes focus provides a clearer basis for care planning and briefing providers (Qureshi et al. 2000). Bearing these provisos in mind, in consultation with all stakeholders, we devised outcome-focused documentation structured in such a way that the professional is prompted to assist the service user to express and record their desired outcome.

The OCA assumes the professional has a capacity to act creatively, to put aside the idea of professional as person responsible for arranging services, in favour of acting as a facilitator, enabling the service user to achieve the desired outcome/s. The approach also assumes that the service user is in control of the process. This is however not a new idea at all.

The modern challenge is to provide alternatives to current practice so that workers and disabled people can share expertise in barrier identification and removal, both at the personal level (for the individual setting their own goals) and at the social level where public facilities need to be made truly public (and not just for able-bodied citizens) (Finkelstein 1991: 35).

Twelve years ago that was seen as groundbreaking and out of reach of most disabled people experiencing social care services. Interestingly, every part of that statement is exemplified in the OCA, but depressingly, the introduction of outcomes is still currently seen as innovative, unusual and difficult to procure in practice.

### **Beginning work on outcomes**

The outcomes focus, as operationalised in this project, locates the service user at the heart of assessment processes and regards their requirements as paramount. The aim and objectives of the work to be done (the outcomes) are identified by the service user through a process of negotiation with professionals from social services. This did not sit easily with current professional practice in the local authority at the project outset. Most specifically, 'expert power' is threatened by the introduction of outcomes as conceptualised in this project (French 1995) since the professional is directed to act as facilitator, ceding control and responsibility for the achievement of the outcome/s to the service user.

All staff in social services that are in contact with disabled service users (senior managers, care managers, occupational therapists, community care workers, sensory impairment workers) were trained in the use of the outcome-focused documents. This comprised an initial training session, group work and discussion with live examples, followed by on-going support meetings over a 6-month trial period – the researched trial implementation (RTI). All outcome-focused documents were collected and assessed by the research team for correct usage of the outcome focus and all staff and participating service users were interviewed. The discussion below concentrates on emerging practice issues to date.

### ***Practice issue number 1: the problem of outcome not 'needs' identification***

As noted above, previous to the introduction of the outcome focus, the task of these professionals was the identification of 'needs'.

Professionals most often saw the solution to these 'needs' as a 'service' (latterly in-house provision, most recently from a mixed set of statutory

and voluntary providers).

The majority of staff from all grades eventually grasped the key differences between focusing on needs and focusing on outcomes. However, some staff experienced difficulty in moving from 'needs' to 'outcomes'. In these cases, practice did not substantially change and staff continued to record 'needs' on the outcome-focused documents. This was obviously occurring and it looked most peculiar. Thus, where the outcomes are to be recorded we had examples under 'health' stating 'to use the toilet' and the planned action to achieve the outcome being 'raised toilet seat'. This restricted and restrictive mode of working that was being used by these professionals prior to the project proved singularly impervious to the introduction of the outcomes focus.

Depressingly, staff in these instances failed to grasp the difference between the identification of a need and an outcome. To be clear, the research team were not disputing that functional items are important to service users and therefore must be recorded as important in cases where they are required. The staff in these instances however, were making these functional items the whole focus of their work and this reduces the possibilities of exploring the whole context of the service user's aspirations (their outcomes), demeans service users by focusing solely upon bodily functions in this way and reinstates (and in many ways reinforces) the expert power of the professional over the service user. These facets of this type of working also compound each other. Reducing interaction with service users to the resolution of functional items is the antithesis of the OCA, since it limits, rather than expands, service users' aspirations.

### ***Practice issue number 2: problems with width and breadth of the OCA***

The concepts underpinning the framework were purposefully 'wide' in orientation, to facilitate the broadest possible consideration of the options available. Professionals struggle with both the width and breadth of the framework in several ways. Firstly, in using the new care plan, some feel a need to cover all the items in the framework (despite instruction to the contrary). However, obviously not all items are appropriate for all service users. One professional raised at a monitoring meeting that the documents are inappropriate because she worried about feeling obliged, (when working in this cover-all manner), to raise the issue of 'employment' with a terminally ill service user. In this case, the professional's decision was therefore not to use the outcome-focused documents with terminally ill service users on a point of

principle. This, it was claimed, was because the only 'outcome' they could see was the service user's death and they considered it morbid to discuss this. Despite support and encouragement by the research team this professional singularly failed to make the leap of imagination to consider that terminally ill people may have outcomes they wish to achieve and that working in this way can still prove to be useful.

***Practice issue number 3: falling back into provider of service mode***

Another feature of the old 'needs-led' system was that professionals appeared to rush to reach a service solution. This continued under the outcomes project when, instead of conducting a dialogue on the service user's desired outcomes, the professional 'leaped into the fray' – cutting short the conversational element in a rush to identify a solution that is a service (generally a service that can be readily accessed by the professional only). This was found to sometimes result from an over-developed sense of responsibility on the part of the professional, but was also sometimes linked to pressure of work and burgeoning case-load.

Cases were noted where the professional clearly does act as facilitator and the service user does identify their desired outcome. However, at this point, sometimes the professional 'forgets' that all stakeholders have both a duty and a responsibility to work towards this outcome and moves back into provision mode rather than enacting their envisaged role. An example of this is a case that was adhering to the outcomes framework at first. The service user identified a need for training in computer/IT skills that the professional noted. The professional however, then identified a class (which should have been done more appropriately by the service user) and set about identifying transport to the class. However, when this proved problematic (no accessible buses were available), the professional then took the service user there every week, acknowledging to the research team that this was not actually part of their job description, or a good use of their time. This example demonstrates that there are various places within the process at which the professional can 'revert' to the type of traditional practice that assesses, codifies and provides for identified 'needs'. It is interesting to consider what ought to have happened in this example; should the professional have joined forces with local disabled people campaigning for an accessible bus service; should they have used information resources to identify funding sources to enable the service user to arrange transport? Both of the latter would adhere to the spirit of outcome-focused social care practice.

#### ***Practice issue number 4: 'asking for the moon'***

Professionals were concerned that service users would ask for outcomes that could not be supported and that, given resources available, it was impossible to provide. Experience of using the outcome focus with other service user groups however, has proved that service users rarely do this, (Qureshi et al. 2000).

Under the OCA, we told the professionals in training, you are *not* wholly responsible for the achievement of the desired outcome. The outcome-focused documents support this as there is space to record the part being played by other stakeholders, crucially, the service user themselves, informal carers, professionals from housing departments and so on. On the whole, this was welcomed by professionals, who, under the 'needs' approach had felt pressured to meet them all, and invariably, inadequate when this was unachievable. This did not wholly dispel professional anxieties however, although it should be noted here that these were more hypothesised and voiced as concerns than actually experienced in practice by the professionals in question.

#### ***Practice issue number 5: reluctance to move outside of narrow service solutions***

Professionals demonstrated a reluctance to move practice outside of a range of 'safe' narrow, clearly delineated, service solutions. This has been noted before in previous studies (Harris and Bamford 2001). It would be easy to apportion blame for this at the feet of the professional, however, we have some initial evidence that service users may approach social services with a narrow service solution in mind, often because they know someone who has obtained that service through this means. So for example, a service user may know someone who has obtained stair rails and approaches social services with this in mind for themselves. Under this circumstance, the outcome-focused approach, which assumes that the service user would start from first principles by identifying a desired outcome of 'access to all areas of the home' before discussing creative solutions, can fail to get off the ground. Thus, both the professional, through the rush to reach the service solution stage and the service user through limiting requests to functional items or discrete services, may prematurely close off avenues to the pursuit of the desired outcomes.

#### ***Practice issue number 6: inability to grasp/reluctance to accept the outcomes concept***

Not all professionals find it easy to understand the concept of outcomes. Some, as discussed above, struggle with the differences that come

when moving away from 'needs' especially when they have been trained in and have used for many years, a very different style of working. Some professionals with a health background (particularly occupational therapists) struggle to accept the framework and in particular dislike the width and breadth of its coverage for two reasons. Firstly, they expressed a preference for 'assessment instruments' that permit the explicit inclusion of 'functional categories' such as 'toileting' and 'feeding'. This issue arose on a frequent basis in support sessions and the OCA was decried for its deficiencies in this area. In actual fact, the core activities underlying all these concepts could easily and appropriately be encapsulated on the outcome-focused documents, under categories of 'health' and 'nutrition'. Whilst the process of including all stakeholder comments into the design and approach was protracted and wide-ranging, the research team refused to incorporate functional categories that focus on deficiency within the outcomes framework since we consider the terms in the outcomes framework to be both more respectful to service users, more egalitarian in approach and more in line with the spirit of the social model of disability.

Secondly, the outcome-focused documents contain on the first page a direction to the professional to write within a box titled 'summary of presenting situation *as seen by service user*' (italics added). The notion of the service user's priorities being delineated and expressed prominently as the focus for all later work, caused a few professionals considerable anxiety. Many problems were anticipated and proclaimed with both the prominence and shift in power relations inherent in the directive, although the vast majority were, in actual work situations with service users, unfounded.

### ***Practice issue number 7: relinquishing expert/professional notions of power***

Some professionals proved unwilling to allow service users to sit in the driving seat – not always for the reasons of 'fear of becoming redundant within the profession' either. Power struggles ensued, particularly with the group of occupational therapists. These objections were couched in terms of issues of 'professionalism' (for example, giving excuses for not using the new documentation and approach as these would diverge from those approved by the professional membership organisation of occupational therapists). 'Expert power' is threatened by the introduction of outcomes. This is because the outcomes focus as practiced in this study, directs the professional to place the identification and achievement of the service user's desired outcomes as paramount.

The research team heard several excuses for not adopting outcomes. For example, one excuse was that the service user was 'not able to engage fully due to impairment'. This was said about a service user who has Multiple Sclerosis and who has fluctuating cognitive impairment. In these cases the research team found it difficult to understand why the identification of outcomes cannot take place at a time when the service user feels well and is not done when they do not. This could be another example of the rush to reach a service solution, but is more likely to denote that the timing of work is still more convenient to the professional than to the service user. Either way, it appears that the notion of the centrality of the service user's role is lost in such cases.

In one outcome-focused document the professional is prompted to record the desired outcomes of the service user. The document includes the outcomes framework with a column at the side for descriptive information. One problem noted however was that documents were returned with insertions such as, 'Mr. X wants to be able to do Y' rather than 'to do Y' (as would be the case if the service user had been steering the interaction). These instances were early indications that some professionals were struggling to 'convert' to the outcomes focus and were reverting to their former practice of expressing their expert judgement as to what should happen, or be provided.

The outcomes framework, training and documents were designed upon the premise of equality between service users and professionals, with the in-built assumption that professionals would act as facilitators in the service user achieving their desired outcome/s. Some professionals in the study have so far proved unwilling to allow service users to enact this role. Notably these professionals are mostly occupational therapists, implying that training and practice in medical settings does not sit easily with the outcomes ethos. Interestingly, care managers, community care workers and sensory impairment workers, whose professions are more influenced by the social work tradition did not appear to experience such conflict over their professional standing. A number of 'excuses' are given for the failure to shift practice in this way. For example, the researchers were told that the service user would 'not be able' to engage with outcomes fully due to the nature of the impairment. In these circumstances, professionals appear to feel honour-bound to 'take over' rather than seek a creative solution that would adhere to the spirit of the outcomes focus.

***Practice issue number 8: fear of 'Big Brother'***

Some professionals were concerned that their employers will use the

OCA, and the greater accountability it affords, to 'check up' on staff performance. In other words, they fear that assisting service users to detail outcomes and documenting these in depth may highlight professional inadequacy in either recording or professional practice. As the project continued over an extended period of time, both the use of the new documents and practice were subjected to regular assessment by the research team and scrutiny by the management level of the local authority.

In the majority of cases, staff had high levels of professional competence at the outset of the project and these staff did not register disquiet. However, some staff who had remained resistant to innovations over a considerable period of years, were clearly threatened by being placed in the limelight by the outcomes project. Some staff were not using the officially sanctioned documentation at all, as they preferred other forms that, at some time in the past, had been allowed. These professionals particularly struggled with the new outcomes documentation, because although it was built on the officially sanctioned forms, they had to struggle with two innovations. In many cases, criticisms levelled at the outcomes documentation in such cases, proved to be at items on the officially sanctioned forms (that had not been changed by the researchers). All professionals are accountable to their employers, and those in the provision of public services also have a duty to react responsively to their customers. The researchers found it somewhat curious to have to point this out.

## **Conclusion**

The intellectual puzzle for future stages of the project is to disentangle which of the practice issues identified are caused by staff misunderstanding the outcomes focus, misunderstanding the social model (or both) and the extent to which any of these problems are intentional or accidental. Without doubt, the practice issues identified in this chapter demonstrate that enacting the OCA is challenging for professionals and forces them to reconsider a number of assumptions about their daily practice with service users.

Some professionals appear to have a problem in moving from the identification of 'needs' to 'outcomes'. Partly this appears due to entrenched patterns of working with service users, in which professional practice has built up over a number of years. Moving outside of the parameters of these patterns causes professional anxiety. When this occurs it is generally professionals such as occupational therapists with health service training who experience most anxiety. At least some of

this anxiety (and consequential reluctance to operationalise the OCA) appears to be caused by reluctance to relinquish expert power. Interestingly, this is not always due to a wish to retain employment, but seems more bound up with a fear of the consequences of failure to achieve the more aspirational items that service users identify when using the OCA. Under the social model, we should of course expect that any challenge to professional power and status will be resisted (Oliver 1990) but the form this resistance takes, appears to change over time in response to local circumstances.

Some professionals fall back into provider of service mode instead of thinking and acting creatively with service users to generate solutions to social problems. Some professionals also appear to show reluctance to move outside of narrow service solutions. This again is caused by the explicitly aspirational tone of the OCA. It does not appear to be directly related to any tenets of the social model of disability but is caused by professional habituation in relying upon sets of 'safe' service solutions. Assisting professionals to step outside of these narrow service solutions and engage with disabled people's aspirations is an on-going objective for the research team.

Although some professionals claim an inability to grasp the outcomes concept, this is not always wholly believable, since it is often the least trained, less professionally educated staff who manage to operationalise the OCA with the least amount of tribulation. Undoubtedly, the outcome-focused documentation confronts some notions of professionalism and the right to practice within certain professional codes, head-on. The research team and management view these conflicts as areas for further work.

The professional fear of 'Big Brother' that the OCA appears to stimulate may be well founded. Although this was not an intentional aspect of the project remit, the OCA could certainly be used for this type of purpose by social services management. For this reason, although not designed for this purpose, staff may see outcomes as supporting this intention.

The research is incomplete, as noted previously, but the omens are good to date. This chapter has concentrated upon issues arising to date and many of these concern conflicts of interest and notions of professionalism. However, it should be noted that even at this early stage, service users appear to value the OCA and appear comfortable with setting goals and working towards them. Several service users of

long standing contact have noted in surprised and delighted tones that this is the first time they have been asked for these types of views, or that professionals have discussed a distinct end product in working with them. Service users also appear to welcome the greater accountability and personal control afforded by the OCA. The challenge of introducing an outcomes approach that incorporates elements of the social model of disability has raised a number of professional practice issues that the research team will continue to address and consider.

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