

Social Model Assessment Team Pilot Project
Essex Social Services
Report of Evaluation

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Introduction

1.1 The pilot Social Model Assessment Team was set up in 2003 and ran for 12 months until March 2004. The evaluation started in May 2003.

1.2 The aims of the evaluation were to:

- help members of the pilot Social Model Assessment Team (SMAT) to self-evaluate their assessments against a social model of disability
- determine the extent to which the pilot project has delivered social model assessments
- identify any barriers that the project experienced in carrying out social model assessments
- help Essex Social Services decide whether/how to continue the pilot.
- help Essex Social Services decide whether/how to disseminate/implement the findings within the main teams.

1.3 Appendix 1 contains a briefing on the social model of disability and how it applies to adult community care services.

2. Self-evaluation

2.1 A self-evaluation form for the Team was developed, in consultation with representatives from Essex Coalition of Disabled People. Members of the SMAT filled in self-evaluation forms relating to the assessments they carried out, and submitted them to the research consultant for comment. Three feed-back meetings were held to discuss these. Discussions were also held on specific assessments where Team members were finding it difficult to identify a social model approach. These self-evaluation forms were found to be a useful tool in encouraging social model assessments. A copy is attached at Appendix 2.

2.2 Initial analysis of the self-evaluation forms filled in by members of the SMAT found that in a number of cases they were focussing on impairment as the barrier. This meant that sometimes there was

limited attention paid to how the barrier could be overcome. For example:

- 'not able to use the phone'
- 'poor mobility'
- 'leg swell which causes pain and discomfort'.

2.3 At the first feed-back meeting we discussed how focussing on impairment limited the opportunities for helping to bring about an improvement in someone's life. A social model approach to the above three examples would identify that the 'problem' in each case was the lack of appropriate response to needs relating to impairment, that is:

- lack of assistance and/or equipment to use the phone
- lack of assistance and/or equipment; inaccessible physical environment, e.g. steps
- lack of advice and information concerning impairment; lack of appropriate medical and/or nursing care.

2.4 The Team recognised that a social model approach to assessments does not deny impairment and the difficulties associated with it. Instead, by separating out impairment from disabling barriers, it then becomes possible to respond more appropriately to both sets of needs.

2.5 There were also a number of situations where someone's state of mind was seen to be a barrier. This could take the form of: a negative attitude towards themselves as a disabled person (which resulted in, for example, a reluctance to engage in social activities); depression (manifest in, for example, a lack of motivation); agoraphobia (resulting in a very poor quality of life). When assessors focussed on someone's state of mind as a barrier this could result in them feeling that there was little they could do for the service user. In contrast, a social model approach enabled identification of action that could be taken.

2.6 Members of the SMAT continued to fill in self-evaluation forms and to submit these and COM3 forms for comments. They also used their own Team meetings to discuss particular cases and to assist each other in shifting their ways of thinking. By the third feed-back

meeting with the Team, in September 2003, both the consultant and they were more confident that they were using a social model approach in their assessments.

3. Analysis of assessments

3.1 The progress that the Team had made was evident when a comparison of assessments that they carried out was made with a sample of assessments done by their social work and occupational therapist colleagues.¹

3.2 Assessments carried out by the Social Model Assessment Team contained more information about service users' aspirations, and less about their impairment². This was partly because the SMAT used a form which asked about aspirations whereas neither social workers nor OTs from other Teams had this heading on the forms they used. Moreover, while OTs in the SMAT used the same form as the social workers (which included the heading concerning aspirations), other OTs used a form which included a page on functional assessment.

3.3 Assessments carried out by the Social Model Assessment Team contained more information about service users' views.

3.3.1 Analysis of COM3 forms completed by SMAT social workers found an average of 11 lines of information under the heading 'Service User's Views' and in addition most forms also contained information under the heading 'Aspirations'.

3.3.2 In contrast, the section on Service Users' views in assessments carried out by a sample of other social workers:

- had an average of 7 lines under 'Service User's Views' (3 forms were unusual in that they had 24, 26 and 21 lines: if these 3 are excluded the average is 5 lines).

¹ Consideration was given to providing extracts from assessments to illustrate some of the points below. However, this was rejected as it was felt that the information was too personal to each service user and their confidentiality would be too easily contravened.

² Comparisons are between initial assessments and did not include reviews.

- the information provided under the heading 'Service User's Views' sometimes contained the assessor's views rather than that of the service user: e.g. 'Wife has enabled him to stay at home longer than I thought possible but cannot cope any longer.'
- in the sample of forms completed by PI social workers, 15% contained no information under the heading 'Service User's Views'; in contrast, all the forms sampled from the SMAT contained information under this heading.

3.3.3 It was not possible to do a similar quantitative comparison of how much information OTs in the SMAT recorded under the heading 'Service User view' with that recorded by other OTs, as the former forms were typed and most of the latter were hand-written. It seemed, however, that the OTs in the SMAT were recording more information about service users' views, particularly because these were also recorded under the heading of 'Aspirations' which did not appear on the forms used by other OTs.

3.4 Assessments carried out by the Social Model Assessment Team had a better coverage of the areas contained in the Equal Lives Strategy.

3.4.1 Assessments carried out by social workers from the SMAT were more likely to include information under headings relating to activity outside the home – transport, access to goods and services, education and employment.

3.4.2 The OTs in the SMAT used the same form as the social workers – and this had the Equal Lives headings on it. They were therefore prompted to include information under these headings in comparison with other OTs whose form did not have these headings.

3.5 Assessment forms completed by the SMAT social workers were more likely to use language which any of us would use to describe our lives and our needs. This language reflects a greater respect for the person's privacy and dignity. The following is a list showing some examples of the contrasting language used by some PI social workers and SMAT social workers:

| | |
|----------------------------|----------------------------------|
| care | assistance |
| attend to personal hygiene | wash |
| toileting | go to the toilet |
| caring duties | assisting his wife |
| mobilising | walking and moving about |
| nutrition intake | meals |
| hoisting | using a hoist |
| transfer | get out of bed/chair/wheelchair. |

3.6 The goals that were identified by SMAT assessments were more likely to be articulated in terms of what people wanted to do. Those assessments completed by PI social workers and OTs were more likely to identify services or equipment as the goals. It was particularly apparent that using the heading of 'Aspirations' had helped the person being assessed to move away from merely requesting a service or piece of equipment that they thought might be available. Instead, people had spoken of what they wanted to do, achieve or change. SMAT assessments were therefore more likely to fulfill the requirement under FACS of recording 'presenting needs', before moving on to determine 'eligible needs'. They were also more likely to be needs-led rather than service-led assessments.

3.7 The assessments completed by PI social workers and OTs were more likely to be limited to an account of the limitations of someone's life, often posed in terms of the effect of impairment. In contrast, assessments completed by SMAT were more likely to identify the things which a person was currently having difficulty doing, what was causing the difficulty and then set out options for addressing the difficulty.

3.8 SMAT members were of the opinion that assessments based on the social model of disability tend to take more time and may indeed take more than one visit. They feel however that the responses to such assessments are more likely to add to the quality of someone's life and to prevent crises in the future. Unfortunately, it was not possible, within the timescale allowed for the evaluation, to assess whether this is correct.

4. Service users' experiences of assessments

4.1 A postal questionnaire was developed, in consultation with representatives from Essex Coalition of Disabled People. Service users who received an assessment from the SMAT were sent the questionnaire asking them for their views of the assessment and its outcomes. A total of 79 questionnaires were sent out and 34 returned – a response rate of 43%.

4.2 Ninety percent of respondents said that the assessment covered all the things they wanted it to cover, while 94% said the assessor encouraged them to talk about their needs and difficulties. A smaller percentage (61%) said that they can now do things more easily as a result of the action following the assessment (16% said they were still waiting for the service or equipment to be provided). Amongst those who reported a positive change following the assessment, the most common results were being able to move around their home more easily (55%) and being able to attend to personal care more easily (also 55%). Forty-five percent said they felt more confident, and 40% more in control in of their lives. Smaller percentages said they relied less on family for help, felt less isolated and had more choices in their lives.

4.3 Those who added comments on the form (or completed the questionnaire over the telephone) said things like: 'helped me live more normally'; 'by asking me what I need rather than forcing me to have thing I don't want...I feel more in control'; 'made life much easier for me'. The few negative comments mainly concerned frustration that it was taking so long to process, for example, a Disabled Facilities Grant, or sort out a disabled parking bay.

4.4 An information schedule was written to be used by the Equal Lives evaluation and a sample of those returning the postal questionnaire are being interviewed as part of the Equal Lives evaluation being carried out internally.

5. Joint working

5.1 Members of the Social Model Assessment Team felt that one of the most valuable aspects of the pilot project was the co-existence of social workers and occupational therapists in the same Team. There were four advantages associated with this:

5.1.1 Early input by OTs meant that personal care did not have to be provided as an interim measure. Provision of aids and equipment enabled some people to maintain or regain physical independence and a number of service users spontaneously mentioned their appreciation of this when returning the postal questionnaire or filling it in on the telephone. This had implications for patterns of expenditure by social care and OTs and is discussed below in Section 8.

5.1.2 Some assessments were done jointly by an OT and social worker visiting together. This encouraged a more holistic approach to people's needs (thus promoting the social model of disability) and speeded up the whole process of assessment and responding to needs. A number of service users made spontaneous positive comments about joint assessments when returning their postal questionnaire or completing them over the telephone.

5.1.3 The presence of OTs in the same team as social workers meant that, if a social worker identified a need for an OT assessment, they could ask an OT in the Team to visit. This meant that service users did not have to join the waiting list for an OT assessment but received a much quicker service.

5.1.4 OTs said that they were less likely to refer cases to social workers than in the past. Instead, they tended to do more co-ordinating and pulling together of responses to need than previously, working with social workers in the Team when necessary.

6. Assessment forms

6.1 The Team adapted the COM3 form used by social workers and the last part of the OT2 form used by occupational therapists. They added the heading 'Aspirations' to the sections of information

gathered during the assessment. The results of the assessment were summarised on an Action Plan, with three main headings 'Barriers; Objective; and Responses'.

6.2 One of the social work senior practitioners devised a questionnaire which could be sent to service users before an assessment visit, to help them prepare for the assessment. This was discussed as part of the evaluation and amendments were suggested: a copy of the amended questionnaire is attached at Appendix 3.

6.3 Analysis of the assessments carried out by both OTs and social workers in the Social Model Assessment Team indicated that 'Aspirations' was the most useful heading on the COM3 form, in terms of encouraging a social model perspective.

6.4 The process of using the self-evaluation form also led the Team to conclude that documentation which encourages a separating out of impairment from disabling barriers helped to promote a social model approach to assessment. Assessment forms should therefore ask information about both impairment (functional limitations, pain, etc) and disabling barriers.

6.5 The Action Plan format - which summarised the results of the assessments under the headings 'Barriers; Objective; and Responses' - helped to encourage a social model response. The Action Plan also recorded the service user's assessment of whether each need was critical, substantial, moderate or low, alongside the assessor's judgement of priority. This was found to be a useful way of challenging that the assessor had properly considered the priority rating of each need.

6.6 In contrast, it was felt that, while existing COM3 forms prompt assessors to cover the headings in the Equal Lives strategy, they do not encourage a social model approach to assessment.

7. Allocations and caseloads

7.1 Information was provided to the evaluation on the allocations and caseloads of the Social Model Assessment Team and other social workers and OTs.

7.2 Analysis of these statistics (which is set out in Tables 1-4) found:

- Over a six month period, June-November 2003 the average monthly caseload of the senior practitioner post in the SMAT was 18, in comparison with an average caseload of 25 for a comparable PI senior practitioner. The average caseload of the social worker in the SMAT was also 18, compared with 21 for a comparable social worker in another Team. The social work assistant had the same average monthly caseload as a comparable social work assistant over the four month period June-September (the social work assistant in the SMAT left in October).
- Over the same six month period, the OT senior practitioner in the Social Model Assessment Team had an average monthly caseload of 14 in comparison with 25 for an equivalent fieldwork OT; the occupational therapist had 18, compared to 28, while the OT assistant had 21 compared to 36.
- Allocations were also lower. A total of 52 social work allocations to the SMAT were made over the four months, June to September (an average of 13 per month) compared to 81 to equivalent PI social workers (an average of 20 per month). In the case of occupational therapists, a total of 59 allocations were made to the SMAT over the 6 month period, June to November (an average of 10 per month), in comparison with a total of 166 to equivalent occupational therapists (an average of 28 per month).
- However the validity of this comparison between OT allocations and caseloads is undermined by the action taken on waiting lists, which affected the number of allocations taken on by fieldwork OTs but not the SMAT OTs.

7.3 In discussion, SMAT members said that they did not feel that statistical information provided an accurate reflection of their working reality. For example, one of the senior practitioner social workers said, 'Previously, the majority of cases I held were what I would call

‘on the back-burner’ – they weren’t closed but I was not actively working with them. I would be working with about 4-5 cases actively at a time and that is the number I am currently working with. The difference is that I haven’t got a large number which are inactive’.

7.4 This situation was thought to be partly because the Team had been taking on new cases, the majority of which were ‘simple’, the work could be done relatively quickly and easily and the case was closed. The social workers generally felt that they were closing cases at a faster rate than before because they were getting more simple cases (because the Team’s initial remit had been to take on new referrals). They hadn’t had the time to build up cases where needs may be higher but which don’t need active working.

7.5 The OTs said that they had a lower caseload than previously but they were now doing much more than they would have done. They didn’t refer cases over to social work teams but tended to do the work themselves, working with the social workers in the Team when necessary. They did a lot more co-ordinating, pulling together, of responses than previously. They did not feel that their caseload contained less complex cases than previously.

7.6 However, it should be borne in mind that assessments which are truly needs-led, holistic and seek the person’s aspirations and views (which are the essential characteristics of taking an approach based on the social model of disability) are likely to take longer than those which are service-led, limited and do not fully listen to people’s views.

8. Expenditure

8.1 Information was also provided to the evaluation on expenditure incurred by the SMAT and other social workers and occupational therapists. Analysis of assessments that resulted in expenditure found that:

- average expenditure following social work assessments carried out by the SMAT was £177.89 per service user

- average expenditure following social work assessments carried out by a sample of PI social workers was £284.87 per service user
- average expenditure following OT assessments carried out by the SMAT was £416.05 per service user
- average expenditure following a sample of OT assessments carried out by field OTs was £270.80 per service user.

NB. Assessments where no expenditure resulted were excluded from this analysis. Moreover, responses which took the form of social worker time or health-funded responses were not costed so were not included in the total expenditure.

8.2 Factors that may account for these differences in average expenditure include:

- There is a view that the SMAT's caseload contained fewer 'complex' cases than other PI social work and OT teams. This might account of the lower expenditure on social care but not for the higher expenditure on OT equipment and adaptations.
- The activity to reduce the waiting list may have reduced the average expenditure by fieldwork OTs during the period of the evaluation.
- In the opinion of social workers in the SMAT their approach was likely to lead to lower expenditure on 'care' as they listened to what people wanted to achieve and responded more imaginatively
- The ability to get a quick OT assessment and response to needs for equipment and minor alterations to the physical environment may have reduced the level of assistance required.
- The above two factors may also account for the increased OT expenditure. If equipment and alterations are provide more quickly – soon after people acquire physical difficulties – they may be more likely to identify this type of response to need. In contrast, when people have to wait some months for an OT assessment they may have come to rely on personal assistance, they may have a more limited view of how their level of physical independence could be assisted by the right equipment or adaptations, and indeed their potential for more physical independence could have been reduced by the wait for enabling equipment.

8.3 Unfortunately, it is not possible, from the information available to this evaluation, to conclude the extent to which any of these factors accounts for the expenditure patterns. However, social workers on the Team stated that, it is their experience that in the PI social work teams, social care services are often provided in the interim while waiting for an OT assessment. By the time an OT assessment is carried out the service user has often become dependent on the personal care provided and there is less potential for using equipment or adaptations to increase physical independence.

9. Responding to needs

Social workers and OTs in the SMAT found that the responses to the needs identified were often not confined to the provision of personal care and/or equipment. People also required advice and information, advocacy, and/or assistance in accessing health, community and other resources. Team members were of the view that sometimes such responses would reduce expenditure on social care. Although these needs could sometimes be met by a referral to ILA, citizens advice bureau and other community resources, Team members often had to spend time seeking out appropriate resources and sometimes these resources did not exist. Team members were of the opinion that their work (and the demands on their time) would have been greatly assisted if they had had access to a comprehensive up-to-date list of community resources and/or if there had been a post with the responsibility of seeking out such resources. It is also important that where such resources do not exist this information informs strategic planning.

9. Conclusions

Finding 1: The adoption of a social model approach to assessments has resulted in better quality assessments. In particular, service user views are more likely to be acknowledged and recorded; the focus is less likely to be solely on impairment; the service user's aspirations are more likely to be identified; assessor and service user together are more likely to identify action to achieve these goals. Social model assessments are an important tool for achieving the Equal Lives strategy.

Recommendation: All assessments carried out by social workers and occupational therapists should be based on the social model of disability.

Finding 2: Although the SMAT thought that they were doing social model assessments at the point that the Team was formed, they concluded – from using the self-evaluation form provided by the evaluation – that they were not. A shift in their thinking towards a social model assessment was brought about by:

- using the self-evaluation form and receiving feedback from the evaluation consultant
- Team discussions
- meetings held with the consultant where individual cases were discussed and more traditional ways of thinking challenged.

Team members found they needed to continue to challenge their approach to assessments in order to keep to, and further develop their understanding of, a social model approach to assessments.

Recommendation: The 'roll out' of the social model approach to assessment to other Teams of social workers and OTs should draw on the lessons learnt from how the SMAT members changed their practice. The 'roll out' should also utilise existing training resources. Moreover, a shift to social model assessments should be recognised as part of continuing professional development. Following discussions with Essex Coalition of Disabled People who are involved in the current training initiative, Principles and Practice of Independent Living (PPIL), it is recommended that PPIL is utilised to

contribute to the dissemination of social model assessments. A proposed training and practice development programme, bringing together PPIL and the 'roll out' of social model assessments, is attached at Appendix 4.

It is also recommended that the questions set out in the self-evaluation tool (see Appendix 2) are used in:

- supervision to check that a social model approach is being consistently applied
- case discussions in Team meetings
- Panel discussions to check that disabling barriers have been identified during assessments.

Finding 3: Current assessment forms do not encourage a social model approach to assessment.

Recommendation

The COM3 and OT2 forms should be amended so that they:

- ask what aspirations the person has (what do they hope for, what do they want to achieve, what do they want to change)
- record relevant impairment/functional limitations (e.g. mobility difficulties, weight, pain)
- record information about environmental, economic and attitudinal barriers and the barriers created by unequal access to services or inappropriate/inadequate services.

Action Plans should then identify the action to be taken to address difficulties associated with impairment and with external barriers. The Action Plan should also record the service user's assessment of whether each need is critical, substantial, moderate or low, alongside the assessor's judgement of priority.

Finding 4: More time is needed for social model assessments.

Recommendation: Managers and organisational procedures should recognise that good quality assessments, based on the social model of disability, require time.

Finding 5: Joint working on the part of OTs and social workers promotes a social model and holistic approach to assessment and is more likely to lead to responses which maximise independence and quality of life. Early response by OTs may also mean lower on-going expenditure on personal care.

Recommendation: Joint teams of social workers and OTs should be created.

Finding 6: Advice and information, advocacy, and access to health, education, community and other resources are likely to be identified as needs if a social model approach to assessment is taken and also if assessments address the issues identified by the Equal Lives Strategy. If all social workers and OTs can do is provide social care and equipment they are unlikely to be able to respond to such needs.

Recommendation: A comprehensive database should be created of health, education and community resources. This should be continually updated. Organisational procedures should recognise the time required to seek out information in response to the full range of needs identified. Information about all aspects of unmet need should be recorded, collated and used to inform strategic planning.

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March 2004.

Table 1: Social workers - Average caseloads per month over a six month period, June-November 2003

| | SMAT | PI Team |
|------------------------------------|------|---------|
| Senior Practitioner | 18 | 25 |
| Social worker | 18 | 21 |
| Social work assistant ³ | 10 | 10 |
| Team average ⁴ | 43 | 52 |

Table 2: Occupational Therapists - Average caseloads per month over a six month period, June-November 2003

| | SMAT | Fieldwork Team |
|--|------|----------------|
| Senior Practitioner | 14 | 25 |
| OT | 18 | 28 |
| OT assistant | 21 | 36 |
| Team average | 53 | 89 |
| Team average excluding OT assistant ⁵ | 32 | 53 |

³ Figures for Social Work assistant relate to four month period, June-September, as Social Work Assistant in SMAT left in October.

⁴ Team averages calculated over a four month period, June-September, as Social Work Assistant in SMAT left in October.

⁵ OT assistant caseload was increased because of action taken on waiting list; the OT assistant in the Social Model Assessment Team was not affected by this action so statistics are not strictly comparable.

**Table 3: Social worker allocations over a six month period, June-
November 2003**

Social Model Assessment Team

| | Total | Average per month |
|------------------------------------|-------|-------------------|
| Senior Practitioner | 30 | 5 |
| Social worker | 29 | 5 |
| Social work assistant ⁶ | 17 | 4 |
| Totals ⁴ | 52 | 13 |

Fieldwork Team

| | Total | Average per month |
|------------------------------------|-------|-------------------|
| Senior Practitioner | 34 | 7 |
| OT | 33 | 7 |
| Social work assistant ³ | 34 | 9 |
| Totals ⁷ | 81 | 20 |

⁶ Figures for Social Work assistant relate to four month period, June-September, as Social Work Assistant in SMAT left in October.

⁷ Totals relate to four month period, June-September, as Social Work Assistant in SMAT left in October.

Table 4: Occupational Therapists' allocations over a six-month period June-November 2003

Social Model Assessment Team

| | Total | Average per month |
|--|-------|-------------------|
| Senior Practitioner | 16 | 3 |
| OT | 21 | 4 |
| OT assistant | 22 | 4 |
| Totals | 59 | 10 |
| Totals excluding OT Assistant ⁸ | 37 | 7 |

Fieldwork Team

| | Total | Average per month |
|--|-------|-------------------|
| Senior Practitioner | 29 | 5 |
| OT | 27 | 5 |
| OT assistant | 110 | 18 |
| Totals | 166 | 28 |
| Totals excluding OT Assistant ⁶ | 56 | 10 |

⁸ OT assistant caseload was increased because of action taken on waiting list; the OT assistant in the Social Model Assessment Team was not affected by this action so statistics are not strictly comparable.

Appendix 1

The social model of disability: Careknowledge Briefing

Introduction

The social model of disability separates out impairment and illness, from disabling barriers or 'disability'. It was developed by people with physical and sensory impairments, but has also been adopted by people with learning disabilities and is equally relevant to older people and to people with mental health difficulties. If adopted in the context of community care policy and practice, the social model of disability opens up exciting possibilities for making a difference to people's lives. It is also key to delivering the government's aims for community care services laid down in *Modernising Social Services* and incorporated into subsequent guidance, *Fair Access to Care Services*.

What is the social model of disability?

The British Council of Disabled People set out the following definitions as the basis for the social model of disability:

Disability is the disadvantage or restriction of activity caused by a society which takes little or no account of people who have impairments and thus excludes them from mainstream activity. (Therefore, *disability*, like racism or sexism, is discrimination and social oppression).

Impairment is a characteristic, feature or attribute within an individual which is long term and may or may not be the result of disease or injury and may

1. affect that individual's appearance in a way which is not acceptable to society, and/or
2. affect the functioning of that individual's mind or body, either because of, or regardless of society, and/or

3. cause pain, fatigue, affect communication and/or reduce consciousness.

Disabled people are those people with *impairments* who are disabled by society.

A disabled person might say, therefore, “My impairment is the fact that I can’t walk; my disability is the fact that the bus company only purchases inaccessible buses.” Or, “My impairment is the fact that I can’t speak; my disability is the fact that you won’t take the time and trouble to learn how to communicate with me.” The social model of disability opens up opportunities to make a difference to people’s lives by focussing on things which can be changed.

This shift in focus is key to developing practice that empowers people. One way of demonstrating how empowering the social model of disability can be is to take a series of statements which are often used about children or adults who have communication impairments, and turn these into statements where the barrier to communication is recognised as being external to the individual child or adult.

A social model approach to communication: redefining the problem

He can't speak.

I'm not used to talking with someone who uses a communication board. I need to get some practice.

She wouldn't be able to tell us what she wants

I don't know how to enable her to communicate with me. I need to find out.

He has a speech impairment.

I'm not used to talking with someone with a speech impairment. I need to spend more time with him. I need to not be afraid of saying I don't understand.

He doesn't understand what I ask him.

I'm using unnecessarily complicated words and sentences. I need to simplify my language.

I'm using the wrong method to find out his views. I need to find other ways of finding out what things feel like for him.

Community care and the social model of disability

When social workers and others use a social model of disability they often comment on the higher level of job satisfaction they achieve. This is because, as one of the pioneers of the social model put it, "The social work task is no longer one of adjusting individuals to personal disasters but rather helping them to locate the personal, social, economic and community resources to enable them to live life to the full" (Oliver, 1983, p.31). This way of working opens up exciting

possibilities of helping to address the barriers that people experience and thereby bringing about improvements to their quality of life.

The social model of disability is entirely compatible with government policy on community care. When the NHS and Community Care Act was passed in 1990, guidance (Department of Health 1991a and b) made it clear that:

- assessments should be needs-led rather than service- or resource-led
- people should be fully involved in assessments of their needs
- unmet need should be recorded and this information used to commission services
- services should be developed and commissioned to respond to the needs of those who require them, rather than expecting service users to fit into services
- service users should be consulted and involved in both the development and the delivery of services
- agencies (health, social services, housing and education) should work together to meet people's needs in a holistic way.

The most recent guidance on eligibility for community care services further promotes these principles. *Fair Access to Care Services* (Department of Health, 2002) requires the separating out of 'presenting needs' from 'eligible needs', thus enabling the identification of unmet need; stresses that service users should be fully involved in assessment and care planning; and requires that assessments cover all aspects of someone's needs, including their involvement in family and wider community life. The Guidance also states that "Councils should recognise that individuals are the experts on their own situation and encourage a partnership approach to assessment".

The social model of disability is compatible with, and should underpin, Person Centred Planning, a key part of the implementation of the national learning disability strategy *Valuing People*. Government policies which seek to combat the

social exclusion faced by mental health service users, and the age discrimination faced by older people, are also compatible with the social model of disability. Moreover, social care services are covered by the Disability Discrimination Act which requires “reasonable adjustments” to be made in order to tackle disabling barriers and promote equal access.

Community care assessments and the social model of disability

Assessments based on the social model of disability do not measure what someone cannot do because of impairment or illness but instead seek to establish:

- What is it that someone wants to achieve/change in their lives
- What is getting in the way of doing this
- What would help?

Assessments based on the social model of disability do not ask ‘What is wrong *with* this person?’ but instead ask ‘What is wrong *for* this person?’ At the core of an assessment based on the social model of disability, therefore, is the identification of disabling barriers.

Disabling barriers are the things, external to the individual, which are getting in the way of them achieving what they want in their lives/fulfilling their potential. This does not mean an assessor cannot talk about impairment or identify needs relating to impairment. What it does mean is, for example, if someone has agoraphobia and says this stops them from working, the disabling barrier here is the lack of effective treatment for the agoraphobia. The point of focussing on the disabling barrier is that something can be done about helping the person to find treatment for agoraphobia. Or, for example, a Deaf person may say they can’t go to see their doctor regularly because they can’t keep asking a relative to provide sign language interpretation for them. The disabling barrier here is the lack of a Sign Language Interpreter (not the hearing impairment). Again, this is a barrier which can be addressed.

The links between impairment and disabling barriers

Impairment and/or illness are often assumed, in themselves, to inevitably create dependency and to lead to a poor quality of life. In fact, a poor quality of life is commonly created by:

- A failure to adequately meet needs relating to impairment. This is a disabling barrier in itself. For example, we know that in many parts of the country people with head injuries do not receive adequate rehabilitation services. There is also evidence, for example, that people with epilepsy do not always receive the best medical advice about medication. In both these situations, a failure to adequately address needs relating to impairment will have a significant impact on people's quality of life.
- Disabling barriers which exacerbate or create impairment or illness. For example, there is evidence that people with learning disabilities experience unequal access to primary health care. Many people with significant cognitive impairment are, as one professional put it, 'not well enough to lead ordinary lives' (Morris, 1999, p.98). This is not because of their impairment but because of the disabling barrier of inadequate access to primary health care.
- Services provided in ways which are disempowering and which may in themselves create disabling barriers. For example, personal assistance to get up in the mornings may not be reliably available at the time someone needs it in order to go out to work. This may lead to the person losing their job (or not being able to seek employment). Unemployment in itself can have a detrimental effect on mental and physical health, so the inadequate service will not only have disabled the person in terms of their employment prospects but may also lead to a new impairment or illness.

However, disabling barriers and the experience of impairment or illness are often closely linked and it can be difficult to separate them out. For example, a community care assessment of someone who is in a lot of pain from arthritis may conclude that the limitations on her life are caused by the condition. Yet if we use a social model of disability, this enables us to see the factors, external to her, which are getting in the way of improvements in her life. It may be that her GP

has not referred her to a Pain Clinic, or to an arthritis specialist. The GP's attitude may have prevented him from making such a referral (he may not take her experience of pain seriously enough) or there may be a lack of information on the part of the woman and/or the GP about these possibilities. The woman's physical environment may make her pain worse – she may have stairs to climb in her house; or warm baths may help with the pain but she may not have assistance, adaptations or equipment to help her get in and out of the bath. The GP's attitude, a lack of information and the woman's home environment are all disabling barriers that can be tackled.

The social model of disability helps to deliver human and civil rights

Disabled people assert that they have the same human and civil rights as non-disabled people. However, disabled people are different from non-disabled people in that they have additional requirements, such as mobility needs, communication assistance, personal assistance, accessible information, and so on. These additional requirements stem from both experiences of impairment *and* from the disabling barriers of negative attitudes and unequal access. If these additional requirements are not met, disabled people's human and civil rights will be denied. Looking at it another way, additional requirements are necessary in order to enable disabled people to have equality of opportunity with non-disabled people.

Additional requirements are usually called needs in the context of social care. If needs (additional requirements) are not met then human and civil rights are denied. For example, a person's human right to a family life and to privacy can be denied if resources are only available to support them in a residential setting. Moreover, impairment can be made more significant by a denial of human rights, and indeed can be created by a denial of human rights. The day to day experience of discrimination and exclusion can create mental health difficulties, for example.

Independent living

The concept of “independent living” is a key part of a social model of disability. It was in the 1970s that a group of people in a Leonard Cheshire Home, Le Court in Hampshire, came to a key understanding about their experiences: that, just because they needed help with going to bed, this should not mean that they had to be put in their pyjamas at 6 o'clock in the evening. This is what the social model of disability is about: a recognition that it is not impairment in itself which restricts what someone can do, but the lack of suitable assistance; it is not impairment in itself which separates someone from society but the attitude that segregation is an appropriate response to their needs. People living at Le Court started to object to the way that society was spending large sums of money to keep them in a situation where they could not choose when they got up, when they went to bed, whether they went out to the local pub, whether they had sexual relationships, and so on. Such a situation separated them from society, denied them opportunities for employment, a home of their own, a family – in other words denied their human rights. All this came about because they did not have any choice or control over how the assistance they required to go about their daily lives was provided. It was this lack of choice and control which made them dependent rather than their impairment in itself.

Independent living is therefore about having choice and control. It is not about doing everything for yourself. Neither is it necessarily about living on your own.

Direct payments are a key (but not the only) way of enabling people who need assistance in their daily lives to have control over how that assistance is provided. Some people may need assistance with physical tasks, such as getting dressed or cooking, or with carrying out their parenting or other caring role. Others may need help with using public transport, or may need support when their mental health needs make them vulnerable. All these needs should be covered in a community care assessment and if eligible, people should be

offered direct payments so that they can have choice and control over how their needs are met.

Strategic Issues

In order to promote the social model of disability within both adults and children's services, the following things need to be in place:

- Disability Equality Training should be provided for all those responsible for planning and delivering services, and for care managers.
- Audits should be carried out to ensure that social care services comply with Disability Discrimination Act.
- Those allocating resources (for example members of Resources Panels) should have an understanding of the social model of disability.
- Assessment forms and other recording systems should be compatible with the social model of disability.
- Information about unmet need, recorded on individual assessments, should be aggregated and used to inform decisions about future service developments.
- Service users should be regularly consulted and involved in the development, commissioning and monitoring of services.
- User-led services should be encouraged, particularly in respect of service user groups who have traditionally been poorly served by statutory agencies (such as Black and minority ethnic communities).
- Direct payments should be available for all those eligible to receive them. Appropriate support to use direct payments should be available, particularly for people who have been under-represented amongst direct payments users: older people, people with learning difficulties, mental health service users, young people.

Conclusion

The social model of disability is a key mechanism for ensuring that social care services and resources work in partnership with people who need support.

Assessments should identify the barriers, external to the individual, which are

getting in the way of human rights. The planning and delivery of services should be focussed on tackling these disabling barriers. All of this opens up exciting possibilities of using public resources in ways which really make a difference to people's lives.

Jenny Morris

July 2003.

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Appendix 2

Social Model Assessment Pilot Project Explanation of Self-Evaluation Form

Please write your name at the top of the form. And also a code which would enable you to identify the service user to whom the form refers.

The purpose of the form is to help you check whether you are carrying out assessments based on a social model of disability. The form asks you to answer three questions under each of four headings. However, to help separate out impairment from disabling barriers, the form first asks you to identify the impairment or illness experienced by the individual. This does not mean their diagnosis or condition but the functional limitations of their body or mind. For example, someone may have a diagnosis of HIV/Aids but this won't tell you what their impairment is. Instead you should put down how the condition is functionally affecting them, for example, extreme tiredness, mobility impaired, partially sighted, etc.

The questions

A. What disabling barriers have been identified in each of the four areas?

Disabling barriers are the things, external to the individual, which are getting in the way of them achieving what they want in their lives/fulfilling their potential. This doesn't mean you can't talk about impairment or identify needs relating to impairment. What it does mean is, for example, if someone is in pain and says this stops them from going out to meet their friends, the disabling barrier here is the lack of effective treatment for the pain. The point of focussing on the disabling barrier is that you can do something about helping the person to find treatment for the pain. Or, for example, someone may say they can't go to see their doctor regularly because they can't keep asking a relative to provide sign

language interpretation for them. You can't get rid of their hearing impairment but you can help them access a BSL Interpreter.

B. What responses have been put in place to tackle disabling barriers?

Previously, you might have referred to a 'care package' being put in place following an assessment. With a social model assessment the responses may not all be about 'care' but may be, for example, helping someone to access a training course, getting an electric meter moved to the appropriate height, as well as perhaps putting in place the more usual social care services. However, hopefully, whatever the response recorded it will be linked to a disabling barrier identified under question A, which is thereby tackled.

C. What disabling barriers remain and why?

This heading is about unmet need. There may not be existing services to help tackle the barriers you have identified, or the person may not qualify for a service. Or it may be that the service itself was not suitable in some way (for example if a residential alcohol treatment service could not provide the assistance that someone required with personal care). Or that the person themselves has chosen not to use a service (for example if someone is not motivated to use an alcohol treatment service – but first check that this is not related to some inadequacy in the service).

The four main headings

The form asks you to record information under four main headings. There is inevitably an overlap between these headings. Don't worry about which heading you put something under – what is important is that each issue which comes up in the assessment is recorded under (at least) one of the headings. It doesn't matter if you mention something under more than one heading.

1. Participation in the community

This heading encompasses a whole range of things: work, education and training, religious, political, and voluntary activities. How someone participates in the community will vary according to their individual circumstances. Their community may be local to them geographically, it may be based on the work they do or the education/training they are engaged in, and/or it may be based on a religious, voluntary or political group. And/or it may be related to their sexuality or to their cultural and family background. The assessment should have identified what type of activity someone aspires to or has previously been involved in and now finds difficult. The assessment would then have identified what was getting in the way of these activities (for example, lack of qualifications to do a particular type of work; the local gay pub being physically inaccessible; lack of help with dealing with the onset of agoraphobia).

2. Private and family life

This heading concerns personal relationships, whether with family, partners or friends. The assessment should have identified relationships which are important to the individual and any barriers which get in the way of the person fulfilling their desired role within those relationships. For example, a person may regret not seeing their grandchildren more and the barrier getting in the way of this happening may be the distance they are from their grandchildren. A person may want to carry out the same parenting tasks as they did before acquiring an impairment but now find that, for example, they do not have the appropriate equipment or support to enable them to pick up their children from school, or that the layout of their kitchen makes it difficult to prepare meals when using a wheelchair. Someone may never have had the opportunity to make many friends and identifies that it is not just their lack of transport but also their own lack of self-confidence which gets in the way of tackling their social isolation. Identifying these factors as barriers will help you identify appropriate responses.

3. Personal autonomy

This heading concerns the amount of choice and control that a person has in their lives. Choice and control can be about small everyday things or it can be about much bigger decisions. It could also concern the support or equipment that someone needs relating to their impairment: for example, if someone has a communication impairment, inadequate communication support or lack of necessary equipment will be a major barrier to choice and control; if someone has a mobility impairment inadequate mobility support or lack of necessary equipment will be similarly disabling; if someone requires personal assistance but has no say in what time a support worker/carer arrives in the mornings, or there are limitations on the type of assistance which is available, this will prevent them having choice and control in their lives. The heading should also encompass the disabling barriers which may get in the way of someone choosing to do something which they enjoy doing or choosing to learn a new skill/take up a new activity. The barriers could relate to physically inaccessible environments, to other people's negative attitudes or, for example, to the person's own lack of experience in trying out new things or worries about pursuing previously enjoyed activities. There will inevitably be overlaps between this heading and the others.

4. Emotional and physical health

Some of the things which come under this heading may well have already been mentioned under the previous three headings. However, it may also be important to identify the disabling barriers which get in the way of maximising someone's emotional and physical health. This could include, for example, barriers which get in the way of dealing with incontinence (perhaps a lack of information, or a lack of specialist advice and possibly treatment). There may also be barriers which get in the way of balancing the benefits of medication with the drawbacks of side effects (such as lack of advice and information, including sharing information with others with similar experiences). In terms of emotional health, isolation may be created by the disabling barrier of a lack of friends, or an unsafe neighbourhood may create a feeling of insecurity; a relationship with a

partner may have suffered because of a lack of help with dealing with the impact of a new impairment or illness.

It is important to remember that a disabling barrier should be recorded even if you think it is unlikely you can help the person tackle it.

Social Model Assessment: Self Evaluation Form (to be completed by social worker following completion of community care assessment)

Difficulties caused by impairment/illness (e.g. mobility difficulties; pain; depression; fear of going out)

Please list

Disabling barriers

1. Participation in the community

A. Disabling barriers identified.

B. Responses put in place to tackle disabling barriers

C. Disabling barriers which remain

2. Private and family life

A. Disabling barriers identified.

B. Responses put in place to tackle disabling barriers

C. Disabling barriers which remain

3. Personal autonomy

A. Disabling barriers identified.

B. Responses put in place to tackle disabling barriers

C. Disabling barriers which remain

4. Emotional and physical health

A. Disabling barriers identified.

B. Responses put in place to tackle disabling barriers

C. Disabling barriers which remain

Appendix 3

Pre-assessment Questionnaire (developed by the Social Model Assessment Team for disabled people to fill in prior to assessment)

This questionnaire is to help us to look at areas of life that are most important to you. It will only take a minute or two to complete.

You do not have to complete it if you don't want to. It will only be shared with yourself, unless you agree for it to be shared with others.

Please hand it to your Social Worker or Occupational Therapist when they visit you.

A Being with people

- 1** Do you see the people that are important to you enough? (*i.e. friends and family*)

Yes _____ No

- 2** Are you able to be with a partner the way you would like to be?

Yes _____ No

- 3** Are you a parent or do you care for someone?

Yes _____ No

- 4** Are there things that you need or wish to do in your role as a parent/carer that you are prevented from doing for some reason?

Yes _____ No

- 5** Are you interested in meeting or communicating with other people who have experienced similar difficulties to you?

Yes _____ No

B Out and about in the community

- 1** Do you have difficulties going out to places that are important to you? For example, leisure activities, pubs or clubs, shops, meetings, friends' houses, places of worship etc.

Yes _____ No

- 2** Are you finding it difficult to get employment, or remain in employment?

Yes _____ No

- 3** Are you finding it difficult to do any training or education which you want to do (either for work or for pleasure)?

Yes _____ No

- 4** Are you finding it difficult to be involved in any voluntary work which you may want to do?

Yes _____ No

- 5** Can you tell us briefly what causes any of these difficulties? (*For example, Transport, access to transport, access to buildings, lack of equipment or assistance, not being able to go out by yourself for some reason, etc.*)

C Being in control of your life

This can be about small things or big things.

- 1 Are there things that stop you having the personal care that you need? *(This may be due to not having the right equipment, not having the right facilities in your home, not having someone else to help you or something else)*

Yes _____ No

- 2 Do you have the health care or treatment you need?

Yes _____ No

- 3 Do you have the information you need? For example, information about your health or disability; about medication and its side effects; about training, education, voluntary work or employment opportunities; about how to meet your needs, etc.

Yes _____ No

4 Is there anything getting in the way of you telling people what you want and what you need?

Yes _____ No

D About how you feel and your physical health

1 Are there things connected to your physical health that stop you doing what you want to do? (e.g pain, medication, incontinence etc.)

Yes _____ No

2 Do you feel lonely or isolated?

Yes _____ No

3 Do you have any worries or concerns that stop you from doing things that you want or need to do?

Yes _____ No

Please tell us anything that you feel would be helpful for us to understand the barriers that you face, which prevent you from leading the life that you want.

Thank you very much for your help.

Appendix 4

Proposal for a training and practice development initiative to 'roll out' social model assessments

1. Principles and Practice of Independent Living: Independent Living
– Working together for change.

This is a one day course, being piloted at the end of March, which will be run by training consultants from the Essex Coalition of Disabled People, with contributions from the Social Model Assessment Team. It is proposed that, after the initial pilot, the course is provided, on a team basis, for all the social worker and OT teams. Each course would take half of a social work team and half of an OT team.

During the one day course, the self-evaluation form (used in the evaluation of SMAT) will be introduced. Participants will be asked to complete this form, following the course, for a minimum of three assessments which they have done.

2. Practice Development

Each group of participants (i.e. half a social work team and half an OT team) will be brought together again for two Practice Development half days. These half days will be facilitated by Susan Hemmings (ECDP consultant) and Jenny Morris. Before each half day they will be asked to send their self-evaluation forms to the facilitators and feed-back will be given on the day. The sessions will also involve case study discussions.

3. Both the PPIL and Practice Development days should be linked to portfolio work and continuing professional development.