

Chapter 8 (In 'Disability Studies: Past Present and Future' edited by Len Barton and Mike Oliver (1997); Leeds: The Disability Press, pp. 115 - 137).

Personal Trouble or Public Issue?

Towards a model of policy for people with physical and mental disabilities

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(First Published 1986)

INTRODUCTION

During the past 30 years, services for people with physical and mental disabilities or impairments have been increasingly thrust in a community direction, as policymakers have come to recognise the financial and the human costs of institutional care. But being essentially a reaction to incarceration, community strategies have grown up in an ad hoc fashion, without a coherent framework to guide policy development. As Richard Titmuss observed way back in 1961, community care occurred outside the hospital; it 'conjured up a sense of warmth and... kindness'; it appeared to be economical, and that was enough for good intentions to be 'transmuted, by the touch of a phrase, into hard-won reality' (Titmuss, 1976). Such a policy vacuum cannot be satisfactorily filled until the position which disabled people occupy in modern Britain has been tackled. Therefore, in this paper, we first undertake a sociological exploration of physical and mental impairment and then, on the basis of that analysis, propose two models which help to untangle the confusion which for so long has bedevilled community social services.

THE INDIVIDUALISTIC PERSPECTIVE

Broadly speaking, two sociological conceptions of disability compete for attention. One is individualistic and the other is social, along the lines of C. Wright Mills' classic distinction between 'personal troubles' and 'public issues'. Writing in the 1950s, Mills maintained that:

Troubles occur within the character of the individual and within the range of his immediate relations with others; they have to do with his self and with those limited areas of social life of which he is directly and personally aware. Accordingly, the statement and resolution of troubles properly lie within the individual as a biographical entity and within the scope of his immediate milieu—the social setting that is directly open to his personal experience

and to some extent his wilful activity. Issues have to do with matters that transcend these local environments of the individual and the range of his inner life. They have to do with the organisation of many such milieux into the institutions of a historical society as a whole, with the ways in which various milieux overlap and interpenetrate to form the larger structure of social and historical life. (Mills, 1970)

What happens if this theoretical taxonomy is applied to physical and mental impairment? When disability is interpreted as a 'personal trouble', sharp distinctions are drawn between different types of impairment and their causes are sought exclusively within the individual: thus, mental and physical handicaps are construed as mere biological deficiencies; mental illness is explained with reference to personal genetics, biochemistry or psychology; and ageing is viewed as an unavoidable physiological process. Not only is causation conceived of in an individualistic way, and without reference to the shared economic, social and political dependencies which give these groups many common needs. Additionally, the assumption is made that deviation from 'normal' behaviour is necessarily a tragic loss or misfortune, particularly where the 'sufferer' is young. Parallels are commonly drawn with death and, like the bereaved, the recently impaired are said to pass through a stage of mourning and to undergo a series of traumatic emotions: shock, denial, anger and depression, before attaining some degree of equilibrium and perhaps finding substitute social roles. With the elderly, there is a heavy sense of inevitability; physical and mental decay is envisaged as a natural part of ageing and the old may be advised to achieve successful adjustment by withdrawing or disengaging from society, to become preoccupied with personal concerns (Cumming et al., 1972; Fitzgerald, 1974; Forsythe, 1979; Oliver, 1981; M. Oliver, 1983; Oliver, 1986). But regardless of age, the individual is expected to cope with disability by adapting himself to society; society is not expected to adapt to him.

Despite its widespread appeal, the individualistic approach has a number of flaws. Even within its own narrow boundaries, personal characteristics crucial to the psychology of disabled people are overlooked; for impairment is assumed automatically to trigger off a single reaction which restricts functioning in all spheres and lowers morale-irrespective of personality, age, sex, type of disability, work and the financial situation, social relationships and previous life-style (Eisdorfer & Cohen, 1980; Greenblum, 1984; Harris & Cole, 1980; Harrison, 1983; Thomas, 1982; Ward, 1979). Most telling, however, is the omission of societal factors because without the socio-economic and political context provided by the 'public issue' or social perspective, we are ill-

equipped to comprehend both the causes of disability and the social policies which it has provoked.

THE SOCIAL AETIOLOGY OF DISABILITY

Whereas the individualistic interpretation ascribes disability to intrinsic mental or physical shortcomings, its social alternative recognises a role in causation for extrinsic factors of a 'structural' and an 'interpretative' kind. These social factors may directly cause or help to cause impairment, but they are also responsible for processes which aggravate the effects of functional limitation and so further encumber disabled people (Walker, 1980a). Let us deal with the direct causes first of all, beginning with the structural ones.

There is an unhappy tendency in the social sciences to ally the structural perspective with the methodological stance of positivism, thereby implying that individual action is determined by the social system and that the 'social world' is 'accessible to understanding and explanation by ... use of the research strategies of the natural sciences' (Cuff & Payne, 1979). However, the term 'structural' does not have to be adopted in a strict, deterministic manner; it can also simply stress the possible impact of economic, social and political institutions without suggesting any necessary curtailment of freedom of action, or indeed the personal autonomy which many disabled people believe that they are able to achieve in spite of their dependencies (Shearer, 1981, 1982; Sutherland, 1981). With the individualistic perspective, any such sensitivity to the structure of society is missing and, consequently, impairment is regarded as a regrettable chance event which randomly afflicts certain individuals. But, in fact, societal factors of various sorts precipitate mental and physical incapacity, and economic organisation is especially culpable. Not only do industrial practices cause pollution and workplace injuries and diseases. Private enterprise may also eschew the firm regulation of defective or harmful goods, drugs and services, and capitalism requires a competitive structure of relationships which may damage mental health (Cochrane, 1983; M.I.N.D., 1979) and give rise to social inequalities which cause the disabilities of poverty associated with low socio-economic class. At the same time, the state itself may increase impairment by intervening in the public interest when there is a risk to some individuals, as vaccine damage illustrates. Obviously, personal biology and psychology on occasions mingle with these factors, but any admission of social causation makes an explanation of disability incomplete unless it takes cognizance of the environmental dimension (Walker, 1980a).

Whatever this balance between direct individual and social causes, social processes also contribute to the aetiology of impairment. For interpretative social scientists, these are the only relevant considerations; the idea of any input from

the individual is dismissed out of hand and disability is seen solely as an artificial creation of society, which would vanish almost overnight if social organisation and social attitudes were transformed. Although comprising a diverse collection of opinions, authors of this ilk are united in their rejection of positivism and anxious to emphasise the meanings which individuals attach to social situations in which they engage (Ingleby, 1981). Thus, the critical issue is how physical and mental impairment is perceived by parties to a social encounter. Perhaps the best example of this interpretative tradition is anti-psychiatry, an area of some controversy in mental health which has generated lively debate. Anti-psychiatry points to the centrality of the social audience in defining a person as mentally ill (Pearson, 1975). To quote the famous American psychiatrist, Thomas Szasz:

In medical practice, when we speak of physical disturbances, we mean either signs (for example, a fever) or symptoms (for example, pain). We speak of mental symptoms, on the other hand, when we refer to a patient's communications about himself, others, and the world about him. He might state that he is Napoleon or that he is being persecuted by the Communists. These would be considered mental symptoms only if the observer believed that the patient was not Napoleon or that he was not being persecuted by the Communists. This makes it apparent that the statement that 'X is a mental symptom' involves rendering a judgement. The judgement entails, moreover, a covert comparison or matching of the patient's ideas, concepts, or beliefs with those of the observer and the society in which they live. The notion of mental symptom is therefore inextricably tied to the social (including ethical) context in which it is made in much the same way as the notion of bodily symptom is tied to an anatomical and genetic context. (Szasz, 1960)

Since decisions about mental illness are so moral and subjective, Szasz argues that the positivist methods of medicine—a perfectly appropriate response to physical disease—are totally wrong in mental health; anti-psychiatry then goes on to accuse most psychiatrists of labelling certain emotions and behaviour as pathological, not due to some inherent and objective quality, but because they offend arbitrary social rules and norms (Becker, 1963; Manning and Oliver, 1985).

Anti-psychiatry, in the main a criticism of medical hegemony in mental health, has usually been content to berate the application of positivist techniques to 'psychological problems', while tacitly accepting their pertinence to physical conditions (Sedgwick, 1982). However, sociologists and doctors have become ever more aware that responses to physical symptoms, pathways to treatment

and the adoption of a sick role are affected by characteristics like age, sex and social class (see, for example, Goldberg and Huxley, 1980; Miles, 1978; Tuckett, 1976; Tuckett and Kaufert, 1978). Thus the uncompromising use of medical concepts in all spheres of health care in losing credibility and some authorities now deny any distinction between physical and mental conditions. Sedgwick, for instance, claims that:

the medical enterprise is from its inception value-loaded because we have chosen to consider as 'illnesses' or 'diseases' those natural circumstances which precipitate... death (or failure to function according to certain values). (Sedgwick, 1982)

Sedgwick's thesis is called in question by the fact that physical and mental conditions carry different social meanings. Nevertheless, the justified attack on conventional medicine has encouraged an interpretative perspective on physical impairment as well, and Victor Finkelstein has taken the short step from physical illness to suggest that physical handicap too is nothing more than an artificial social construct. Finkelstein draws a sharp division between impairment and disability. Quoting from a paper by the Union of the Physically Impaired Against Segregation, he defines

Impairment as lacking part or all of a limb, or having a defective limb, organ or mechanism of the body; and *disability* as the disadvantage of restriction of activity caused by contemporary social organisation which takes no or little account of people who have physical impairments.

Disability is, therefore, a 'special' form of discrimination, or social 'oppression' (Finkelstein, 1980); it is imposed by a society which expects all its members to conform to the yardstick of able-bodied normality, and builds physical and social environments which penalise any 'misfits'.

SOCIETAL STRUCTURE AND DISABILITY

Although important, interpretative thinking is incomplete as a social construction of handicap unless, like recent work by M. Oliver (1983, 1984) and D. Stone (1985), it attempts to address the economic, social and political structures which underpin our value systems and so help to stigmatise disabled people. Some of the best structural accounts of impairment emerge from the literature on ageing which has accumulated on both sides of the Atlantic. In Britain, Townsend blames the tradition of functionalism in sociology, as well as the more descriptive and empirical traditions of social work and social administration (for encouraging) the kind of theory of ageing which

attributes the causation of problems to the difficulties of individual adjustment to ageing, retirement or physical decrecence, while acquiescing in the development of the state, the economy, and inequality.

Townsend declares forcefully that, contrary to the individualistic position, it is society which 'creates the framework of institutions and rules within which the general problems of the elderly ... are manufactured' (Townsend, 1981). His comments apply equally to younger people with physical and mental impairments. Therefore, a sociology of disability must give proper consideration to economic, social and political status.

ECONOMIC STATUS

The economy is a pivotal feature of modern Britain and economic rationality is a central goal. Consequently, society is organised to achieve maximum 'efficiency, productivity and material progress' (Shearer, 1981) and the personal qualities commensurate with these objectives are hallowed-good health, independence, resourcefulness, enthusiasm, energy, ambition, resilience (Harris and Cole, 1980; Topliss, 1982). In the competitive environment of the labour market which expresses these values, disabled people are disadvantaged for at least three reasons. First, the growth of credentialism may undermine the prospects of those who, due to age or an interrupted and inadequate education, have failed to amass qualifications which mirror their abilities. Secondly, while mechanisation and technical change may open up new opportunities for younger disabled people, innovation devalues the experience of older employees and their expiring working life makes them unpopular candidates for retraining. Finally, despite evidence to the contrary, employers often consider all disabled people an unreliable, high risk group unable to reach normal productivity levels and hence unsuitable both for initial recruitment and promotion. The net effect of these trends is that many of working age with physical and mental impairments are located at the bottom of the income ladder, or out of work and dependent upon social security benefits like the majority of the disabled who are elderly (Buckle, 1971; Davoud and Kettle, 1980; Estes *et al*, 1982; Hendricks and McAllister, 1983; Jordan, 1979; Kettle, 1979; Locker, 1983; Maclean and Jeffreys, 1974; Oliver, 1982; M. Oliver, 1983; Taylor and Ford, 1983; Townsend, 1979, 1981; Walker, 1980a, 1981, 1982a,c; Wansbrough and Cooper, 1980; Ward, 1979).

SOCIAL STATUS

Work not only has financial repercussions; there are also spin-offs for social and political status. Ageing is associated with contracting social relationships; and as old people start to play fewer roles and fill more time with home-

centred activities, their links with the community are severed (M. Abrams, 1980; Cumming *et al.*, 1972; Tunstall, 1966; Wenger, 1984). The younger disabled may also experience impoverished social interaction, and for similar reasons. Loss of mobility and negative community attitudes may make socialising difficult; poverty, stemming from retirement, unemployment or poor wages, may cramp leisure pursuits; and without a job to regulate life-activity and serve as a foundation for intercourse, it may be hard to put together social networks (Goffman, 1968; Harris and Cole, 1980; Locker, 1983; Locker *et al.*, 1979; Miles, 1981; Weir, 1981a,b). Townsend argues that the high esteem of the aged within the family helps to compensate for their low 'public status' (Townsend, 1981). Geographical mobility, however, has splintered multi-generational families and many relatives are now too distant to be convivial with elderly or younger disabled kin on a regular basis (Rosser and Harris, 1965; Wenger, 1984). Moreover, in a highly fluid society, where knowledge is quickly outdated, the elderly who do remain near relations lose their worth as counsellors and advisers (Rosow, 1974); and at all ages, dependencies which breach the conventions of family life—for example, husband financially beholden to wife, or frail parent reliant upon adult offspring—may sully relationships and leave the disabled person with tasks insufficient to offset the humiliation from loss of function (Bergmann *et al.*, 1984; Dartington *et al.*, 1981; Dowd and La Rossa, 1982; J. Oliver, 1983; M. Oliver, 1983). But, above all, non-economic family roles in a capitalist society rarely carry the prestige of paid employment. Therefore, although these activities, many in the field of child care, may satisfy elderly women whose lives have always revolved around domestic affairs, they may be second best for the individual of either sex who has been economically active outside the home.

POLITICAL STATUS

Just as economic factors influence social relationships, so they also affect the political status of disabled people. Marx pushed this logic to its outer limits, claiming that the capitalist mode of production so determined 'the rest of the social structure' that 'political and administrative intervention' was unable to 'decisively shape the reality of the economic order' (Mishra, 1977). However, it is possible to accept some elbow-room for political institutions, while still conceding that economic and political status are intimately intertwined in our industrial society, any adult not performing work-linked economic and social roles is a thorn in the flesh of economic rationality and may even be feared as a menace to political stability. There is no one way of handling this trouble spot, but with physical and mental impairment the sick role is deployed to minimise the effects of dependency. When subjected to this status, 'ill' disabled people are, according to their degree of incapacity, excused various duties and absolved of responsibility for their situation, in return for agreeing that their condition is

undesirable and co-operating with 'appropriate' help (De Jong, 1981; Miles, 1981). Any reduction of this process to crude social control is simplistic; there is no conspiracy to divest deviance of its political significance and hence defuse a 'threat or potential threat to the existing ... conditions of society' (Treacher and Baruch, 1981; Manning and Oliver, 1985). Nevertheless, application of the sick role to disabled people does devalue their input to political debate by conveying the mistaken impression that, being indisposed, they are either unable to speak for themselves or have nothing worthwhile to say (Shearer, 1981). Thus, political status is corroded by an apparently humanitarian action.

Consumer engagement in the welfare state is further undercut by the British system of representative democracy which endorses participation by the elector singly and indirectly, rather than more pugnacious forms of political activity. In the absence of direct and effective user participation, disabled people have to champion their interests through pressure groups and the electoral system. Since the mid-1960s, organisations from within the disabled power movement (the Union of the Physically Impaired Against Segregation, the Liberation Network of People with Disabilities, the British Council of Organisations of Disabled People, Disabled People's International) have been fighting to raise the political consciousness of their constituencies (Dartington et al., 1981; Oliver, 1984; Sutherland, 1981). They have met with some success but, unfortunately, there are inherent obstacles to much further progress both in this area of pressure group politics and electorally. A major problem is dogged adherence to economic rationality, which reproaches those who are not fully productive and discourages them from organising around a negatively perceived condition. However, the incoherence of the impaired as a political group also reduces their impact. Splintering along class lines is one cause; handicapped members of the upper and middle classes, with wealth and investment incomes, higher salaries or better superannuation schemes, have a very different experience of impairment to people who must rely exclusively on state social services. But other tensions within the disabled population are important too. The traditional medical approach to handicap, for example, has created artificial fissures between disease categories which obscure common social needs; and as the majority of disabled people are elderly, the distinction between handicap and old age is likewise divisive. In turn, this age profile has implications for the nature of political participation because, although the elderly are growing in numerical terms, they mostly confine themselves to voting at elections and are less likely than younger age bands to take part in more aggressive activities—signing petitions, demonstrating, and founding pressure groups. Satisfaction with the status quo born of past deprivation may be one reason for this passivity; and the 'new' elderly, and younger disabled people may be more ready to complain. But whatever the intensity of their grievances, the impaired of all ages encounter practical difficulties when attempting to voice

political opinions. Poverty and poor health may sap their energy; immobility and inaccessible public buildings may constrain them; and they may have little confidence in their powers of verbal or written communication. The upshot is that citizens with physical and mental disabilities are relatively powerless to shape the formulation and administration of policies which play a fundamental part in their lives (Borsay, 1986) [1].

THE SOCIAL POLICY RESPONSE

In dismantling the individualistic perspective and assembling an alternative social one, we have so far dealt with the social causes of disability, considering the direct connections between socio-economic organisation and the incidence of impairment, interpretative views of the social construction of disability, and the ramifications of societal structure for economic, social and political status. Within the context of this paper, however, it is not adequate to posit that disability is socially manufactured, by whatever means. To examine more fully the pock-marks in community care, we must now tease out the implications of our sociological analysis for policy development.

Since the conception or explanation which is given to a problem 'contains an implicit prescription for policy' (Townsend, 1979), it is possible to outline an individualistic and a social model of community social services for disabled people. At present, the individualistic perspective has a stranglehold, and provisions exhibit many of the characteristics summarised for this model in the Table below. Thus, all community care is rudimentary and under-financed. The state leaves families to cope with disability almost unaided. Services-for example, education and purpose-built accommodation-may segregate their recipients from the rest of the community and defy co-ordination. Mechanisms for direct consumer participation are variable in their success. The distribution of benefits neither significantly reduces material inequalities in income and housing, nor achieves equity in health care, education and the other social services. There are few attempts to prevent the economic and social causes of disability. And, last but not least, half-hearted employment initiatives, such as the discredited three per cent quota of disabled workers for companies with more than 20 employees, fail to tackle the labour market discrimination which lies at the heart of ambivalence towards impairment in an advanced industrial society.

TABLE I. Policy responses under the individualistic and social models

	Individualistic Model	Social (structural) Model
Public expenditure	Lower	Higher
State intervention	Reluctant	Enthusiastic
Family and community support	Minimum	Maximum
Service organisation	Segregated Disjointed More unequal/inequitable	Integrated Co-ordinated Less unequal/inequitable
	Producer-dominated	Consumer-sensitive

In sharp contrast, the social models are more conscious of 'the larger structure of social and historical life'. In the past, the interpretative version has not been very relevant to policy discussions. Either writers have by-passed reform within the existing social system and preferred to imagine the disappearance of disability in some future 'brave new world' (Leonard, 1975; Ramon, 1982); or, alternatively, they have lapsed into naive when confronting 'the larger complexes of society', as opposed to 'small-scale structures and relationships'. Thomas Szasz, for instance, shows great faith in the private contract between psychiatrist and client, without appreciating that many most in need of help 'are hardly in a position to compete in the therapy-purchasing market' (Sedgwick, 1982). More recently, groups of disabled people have started to arrange services for themselves, sometimes employing assistants and sometimes on a self-help basis. However, many of those involved are from younger age groups whose impairments (e.g. spinal injury) are typically static. Others may not have the energy or resources to forge innovative patterns of care. Nor may then they be able to offer help, particularly in the early stages of disability; and so mutual aid organisations move towards 'voluntary assistance from longer term members to newer ones' (Richardson and Goodman 1983). Therefore, while accepting the personal significance of such initiatives, they are unlikely to satisfy the needs of the majority of disabled people with the degenerative conditions of later life. It follows that there is more mileage for policy analysis in the structural than in the interpretative version of the social model.

Since the structural approach recognises the societal causes of many disabilities, an ideal package of economic and social policies, ambitious and

wide-ranging, is prescribed. The state would intervene energetically in the organisation of employment to reduce physical and mental damage to workers. Goods of all descriptions would be tested stringently and banned when they were a threat to health and safety. Vigorous attempts would be made to maximise job opportunities for elderly and younger disabled people who wished to work. Generous income maintenance programmes would prevent poverty due to impairment. And to meet housing, health, education and welfare needs, the state would evolve a comprehensive, integrated and co-ordinated collection of services which were equitably allocated in all localities, geared to family and community resources, and politically accountable to their users. Yet if the social model recommends these strategies to combat the faults of individualistic policies, it also reveals that the prospects for successful implementation are slim because the same societal forces which manufacture disability also mitigate against a structural response. Cost is the initial stumbling block. Throughout the twentieth century, public expenditure has consumed an increasing proportion of the gross national product (GNP) and the expansion of social services spending on social security, welfare, health, education and housing has been especially marked. Thus, between 1910 and 1975, during which time total state expenditure grew from 12.7% to 57.9% of GNP (at factor cost), social services expenditure increased sevenfold, from 4.2% to 28.8% (again, at factor cost). When the national product was itself on an upward trend, the level of public spending was less of an issue; profits and real wages grew over time and provided 'the material base for reformism and the welfare state'. As the GNP started to falter, however, government expenditure came under heavy fire and the present intensive assault, dating from the mid-1970s, is conducted in the conviction that our economic difficulties will be ameliorated by better housekeeping. Economists now clash over the details of a strategy for recovery, but neo-Keynesians and monetarists alike agree that public spending, if uncontrolled, is 'a major cause of the . . . economic crisis and must be cut' (Gough, 1979). Therefore, the global cost of a structural policy response to disability is inhibiting (Oliver, 1984), particularly given the ideological commitment after 1979 to replace statutory services with the family and the private and voluntary sectors.

But even if the economy was buoyant enough to fuel an extended welfare state, all-embracing policies towards disability would still be frustrated because of the primacy which is given to economic over social goals. In contemporary Britain, the work ethic is considered essential to economic survival; it is believed that talent and effort must be materially rewarded and an income differential between the economically active and economically inactive preserved, in order that citizens have an incentive to find and keep employment. Consequently, national insurance contributions and taxation are pegged at relatively low levels, and hence a strict threshold imposed on all public expenditure but especially

that directed towards social ends (George and Wilding, 1984). Ironically, however, the emergence of human needs is often closely interwoven with the economic development of industrial societies, and recourse to statutory services by disabled people is no exception. Since the Second World War, the economy has demanded a more geographically mobile workforce and increasing numbers of married women have been attracted back to paid employment. As a result, relatives and friends may no longer live in close enough proximity to help disabled people; neighbourhood networks, generated in some localities by decades of shared residence, may be less supportive (P Abrams, 1980); and women, the traditional and still the most numerous carers, no longer have so much time to spare (Briggs, 1983; Charlesworth *et al.*, 1984; Equal Opportunities Commission, 1980; Green *et al.*, 1979; Jones and Vetter, 1985). These changes are not inevitably destructive; mobility and female employment may enhance living standards and open up opportunities for individuals previously fettered by tight-knit family and community life. Nevertheless, new needs do appear which demand greater statutory support for disabled people and this structural policy is a costly one, with little economic return. Unlike expenditure on education or curative medicine, community care cannot be put forward as a means to improved productive capacity (Sleeman, 1979); nor, in a period of high unemployment, is the release of valuable labour a defence, particularly when many carers are women with few occupational skills who seek part-time work as secondary earners. Therefore, community care for disabled people cannot be pursued through the economic justifications which hold most sway in a capitalist society.

Social services to substitute for relatives and neighbours also contravene the principle of *laissez-faire*, which with its emphasis on self-help reiterates the competitive individualism of the market-place. In the context of families model, which focuses on accommodating disabled people within the structures of 'normal' society instead of showing flexibility in the face of human diversity. Thus, there is a tendency to reduce those who cannot act out the usual gamut of economic and social roles to the trait which stops their proper participation in society; to assume that their differences rule out the possibility of an ordinary life in all spheres; and then to use this 'deviance' to justify separate or segregated provisions which treat special needs (Purkis and Hodson, 1982; Study Group of the 1978 Co-ordinated Research Fellowship Programme, 1980). Professional groups, well to the forefront in identifying these special needs, have from time to time managed to orchestrate policy initiatives; and in the short term, disabled people have gained by the introduction of segregated facilities to replace harsh institutional regimes or gross community neglect. As specialists, however, professionals tend 'to diagnose a problem in relation to what they themselves can offer' and so the welfare state has been carved principally by their pattern of occupational skills

(Walker, 1982b). The resulting division of labour bears little resemblance to consumer needs; for example, the vested interests of teachers has hampered transfer of disabled children from special education, which isolates them from their peers and depresses academic attainment, to standard classrooms giving a better chance of equal opportunities. In addition, competing professional ideologies and fierce rivalry stifle both the co-ordination of help to individuals and the reform of services to bring them more into line with disabled people's requirements not just in the segregated sector but throughout the welfare state (Bytheway and James, 1978; Pascoe and Thompson, 1979; Robinson, 1978). In the longer term, therefore, the separatism and insularity encouraged by professional influence has produced disjointed social services which may be out of step with consumer needs.

Segregation is essentially an extreme form of inequality which isolates and excludes minorities (Webb, 1980), but inequality itself is not confined to special services; integrated policies potentially open to all citizens are also affected. The social security system, for instance, awards to those injured at war or in employment levels of benefit significantly higher than the invalidity schemes, retirement pension or supplementary benefit; and by so articulating the worth of service to society, propagates a hierarchy among state dependants within the disabled population (Shearer, 1981; Topliss, 1982; Oliver, 1984). But even at the top of the pecking order, payments do not always lift their recipients from poverty; and onto this foundation of financial inequality are piled housing and the other material deprivations which arise from low income. Bearing in mind the universal nature of monetary and accommodation needs, equality is a suitable criterion against which to measure policy. However, where needs are not common to us all, thinking in terms of equality serves 'merely to underwrite existing inequalities' (Jones et al., 1978) and, therefore, equitable access to assistance commensurate with personal and social circumstances becomes the appropriate test (Shearer, 1981). The equitable distribution of resources is just as elusive to health care, education and the personal social services as equality is to social security and housing. In both cases, the reason is the alliance of the welfare state to the values of a capitalist economy and in particular to the work ethic. However, where equity is at issue, professional discretion, exercised at the margins in housing and social security decisions, is elevated in importance. Although the professions are not blatant agents of social control, the perspectives which guide their operation do embody a therapeutic model of practice-a 'problem-treatment-cure' approach which with adults concentrates on a return to 'normal' economic and social roles and with children aims for a healthy and socially competent labour force for the future. This emphasis on rehabilitation is devastating for disabled people, where not dramatic change but modest improvement, or perhaps the prevention of further deterioration, is

perceived as the most likely effect of intervention. To begin with, services designed for children and the working population may be peripheral to the needs of individuals with long-term dependencies. But even when help is relevant, the assumption that professional skills are superfluous may encourage the automatic allocation of disability referrals to less prestigious occupational groups, or a second-class service from professionals whose training has instilled the superiority of therapeutic work and devalued association with patients or clients of limited economic potential. It is this allegiance between social services personnel and the state which underpins the inequitable treatment of disabled people (Borsay, 1986) [1].

Paradoxically, shortcomings in the social services obstruct the path to user accountability. In the first place, imperiously supplying assistance and attaching the label, 'illness', to citizens with physical and mental impairments foster a false image and sense of dependence (Purkis and Hodson, 1982) which, when combined with representative democracy's espousal of indirect participation, helps to dismiss them as incapable. However, segregation, inequality and inequity also take their toll; for by discriminating negatively on the basis of disability, they not only reinforce the sick role but also deter campaigning by communicating that impairment is a stigma, to be hidden not brandished. If consumers are written off as incompetent and passivity is promoted, professional control of the welfare state is exonerated and any attempts at more direct participation-Community Health Councils, patients' committees, tenants' associations-are likely to be cosmetic. But this is not surprising. The imperfections of community care stem primarily from tensions which surround dependency in an advanced industrial society; and until these dissonances are resolved, disabled people will continue to suffer from denuded political status.

CONCLUSION

It has been the aim of this paper to develop a model of community care disciplined by a sociological appraisal of physical and mental impairment. To this end, two conflicting interpretations of disability have been compared, one individualistic and the other social. Under the individualistic perspective, disability is presented as a 'personal trouble' and the victim is expected to come to terms with his plight, assisted by relatives and close acquaintances. Under the social perspective, conversely, disability is acknowledged as a 'public issue' and emphasis is placed on the role of society in its manufacture - by directly causing physical and mental impairment; by applying pejorative labelling processes; by operating economic, social and political institutions which are deaf to the needs of disabled people. Naturally, different policies are derived from these two interpretations. In line with its conception of disability,

the individualistic policy response is unhappy to sanction extensive government spending and intervention; it acquiesces in the strain imposed upon families and neighbourhoods; and accepts social services which are segregated and disjointed, unequally or inequitably distributed, and dominated by professionals. From its grounding in the structure of society, the social model prescribes diametrically opposed policies: heavy public expenditure and state intervention; maximum support for carers; and integrated, co-ordinated social services, allocated according to principles of equality or equity and tuned in to consumer needs. But at the same time, this model also demonstrates clearly the problems of moving from individualistic policies, typical of much current provision, to a more socially orientated programme of community care. Of course, welfare goals are not invariably incompatible with the economic rationality which is a hallmark of industrial Britain; for, historically, as Robert Pinker observes:

The political interest in maintaining social order and consensus, the growing awareness that what was good for social welfare was also good for the economy, and the relevance of social policy to military efficiency and patriotic unity have ... contributed greatly to the extension of the welfare state. (Pinker, 1974)

At the same time, however, the cost of increasing any social service quickly becomes prohibitive; and where the beneficiaries hail from largely non-productive minority groups, endemic impediments to change become even more intractable. Better community care threatens work incentives through bigger tax and national insurance bills, without the fillip of an economic return; high profile government-to help relatives, friends and neighbours, to expand and overhaul health and local authority services, to prevent disability-threaten the cherished independence of families and communities, local political institutions and employers; the pursuit of integration, equality/equity and consumer participation threaten the autonomy of the professions and their symbiotic relationship with the state. Given these barriers to change, the social model carries a doubly pessimistic message: yes, reform of community care is pressing but the resistance will be formidable.

NOTE

[1] I am grateful to the editor of the Occasional Papers on Social Administration, in which series this book appears, for permission to use the above paragraph.

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