Explore models of disability

The medical model: is presented as viewing disability as a problem of the person, directly caused by disease, trauma, or otherhealthcondition which therefore requires sustained medical care provided in the form of individual treatment by professionals. In the medical model, management of the disability is aimed at a " cure," or the individual’s adjustment and behavioral change that would lead to an " almost-cure" or effective cure. In the medical model, medical care is viewed as the main issue.

The Social Model : The social model of disability sees the issue of " disability" as a socially created problem and a matter of the full integration of individuals into society. In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the socialenvironment. Hence, the management of the problem requires social action and is the collectiveresponsibilityof society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life.

The issue is both cultural and ideological, requiring individual, community, and large-scale social change. From this perspective, equal access for someone with an impairment/disability is ahuman rightsissue of major concern. The Moral Model: Refers to the attitude that people are morally responsible for their own disability. For example, the disability may be seen as a result of bad actions of parents if congenital, or as a result of practising witchcraft if not.

The empowering Model: Allows for the person with a disability and his/herfamilyto decide the course of their treatment and what services they wish to benefit from. This, in turn, turns the professional into a service

provider whose role is to offer guidance and carry out the client’s decisions. In other words, this model “ empowers” the individual to pursue his/her owngoals. The examples above are only some of the ‘ models’ of disability which have been defined over the last few years.

The two most frequently mentioned are the ‘ social’ and the ‘ medical’ models of disability. The medical model of disability views disability as a ‘ problem’ that belongs to the disabled individual. It is not seen as an issue to concern anyone other than the individual affected. For example, if a wheelchair using individual is unable to get into a building because of some steps, the medical model would suggest that this is because of the wheelchair, rather than the steps. The social model of disability, in contrast, would see the steps as the disabling barrier.

This model draws on the idea that it is society that disables people, through designing everything to meet the needs of the majority of people who are not disabled. There is a recognition within the social model that there is a great deal that society can do to reduce, and ultimately remove, some of these disabling barriers, and that this task is the responsibility of society, rather than the disabled person. Many people are willing to adopt the social model and to make adjustments for people who have a visible disability.

However, they are not as accommodating with people who have a hidden disability, or a disability that is not clearly understood. People with impairments are disabled by the fact that they are excluded from participation within the mainstream of society as a result of physical, organisational and attitudinal barriers. These barriers prevent them from gaining equal access to information, education, employment, public

transport, housing and social/recreational opportunities. However, recent developments promote inclusion.

Anti-discriminationlegislation, equal-opportunity policies and programmes of positive action have arisen because it is now more widely recognised that disabled people are unnecessarily and unjustly restricted in or prevented from taking part in a whole range of social activities which non-disabled people access and take for granted. In my day service, working in a person centred manner is imperative for all the individuals that attend. Respecting their individuality and uniqueness is paramount.

Whilst understanding the medical model is essential to treat conditions, receive pain relieving drugs and identify necessary assistive aids, understanding the social model of disability is equally as essential. As a service we undertook with our service users the task of going out in our local town and seeing firsthand what barriers people with physical/sensory disabilities faced. We identified several venues, e. g. library, bank, park and local indoor market and we set out to identify what barriers, if any our service users faced trying to access the facilities.

The social barriers were evident immediately. The library had stairs with no lift, so it was inaccessible for wheelchair users, the park had extremely uneven footpaths, which was extremely dangerous for people with walking aids and the bank had an electronic door, but only stayed open for 3 seconds so the individual I had accompanied there in a wheelchair would have actually got stuck in the door had I not been there to press the door again quickly to reopen it.

As a service, we supported our service users in writing letters to the organisations explaining the difficulties disabled people faced trying to access their buildings and our service users told us they felt empowered and liberated having done that. As a service, which is named ‘ Our Choice’ that is exactly what it is, the service users choice in what they want to do with their time with us, how they want to do it and with whom.

My role is to ensure I am properly trained to work with a range of person centred planning tools and implement them tools in a person centred way. I ensure that our agency staff and our volunteers understand the ethos of person centred planning and maintain high training standards so that our service users feel respected and empowered at all times.