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## CHAPTER 2

The Social Model in Action: if I had a hammer

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### **Introduction**

A little while ago, Prime Minister Tony Blair stated that the Labour Government's aim is: 'To take down the barriers that hold people back from fulfilling their potential'. It is tempting to suggest that we are all social modellers now! It certainly seems that it is not just disabled people who recognise the potential and usefulness of the social model. However, its rising popularity has coincided with it becoming increasingly contested, not just its definition but also in terms of its usefulness and applicability.

In this chapter, I want to argue that, as the title implies, in the last twenty years we have spent too much time talking about the social model and its usefulness and indeed its limitations and not devoted enough attention to actually implementing or attempting to implement it in practice. This criticism applies both to the disabled people active in the Disability Movement and those academics who have been central to the ongoing progress of disability studies.

In order to develop this viewpoint, firstly, I will provide a brief history of the social model from my own personal perspective as someone who was centrally involved in its elaboration, almost from the beginning. Secondly, I will explore the main criticisms of the social model that have emerged from the Movement and from disability studies. I

do not intend to engage with the disapproving analyses that have been offered from those outside the Movement or in other parts of the academy. Thirdly, I will examine examples of the application of the social model with which, in one way or another, I have been involved. I will focus primarily on a recent project undertaken with Birmingham City Council (Oliver and Bailey 2002).

### **Origins of the social model**

The starting point for the social model was the publication of *The Fundamental Principles of Disability* by the Union of the Physically Impaired Against Segregation (UPIAS) in 1976. It stated that:

In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society (UPIAS 1976:14).

This turned the understanding of disability completely on its head by arguing that it was not impairment that was the main cause of the social exclusion of disabled people but the way society responded to people with impairments.

The more detailed elaboration of the social model stemmed from attempts to apply this insight into practice: firstly, in training of social workers, and secondly, in the design and delivery of disability equality training. More precisely, it emerged out of a course that I was teaching at the time that was the first postgraduate course in what would now be called disability studies. This was based at the University of Kent and was aimed primarily at qualified social workers, although some occupational therapists and others including a few disabled people also enrolled. Essentially, I was trying to provide my students with a way of applying the idea that it was society and not people with impairments that should be the target for professional

intervention and practice. This approach was first introduced to a wider audience at a Royal Association for Disability and Rehabilitation (RADAR) conference in 1982. Subsequently, it was advanced in my book *Social Work with Disabled People* (Oliver 1983).

In recent years there has been a great deal of discussion about different models of disability and what they mean for disability politics, policy and services as well as how adequate they are as an explanation for the experiences that disabled people have. We have seen the emergence of individual and social models, the medical model, the charity model, the welfare and administrative models among others (Finkelstein 1993). As the person who invented the term 'the social model of disability', though not the ideas behind it, I find the arrival of all these different models confusing rather than helpful.

For my part, I prefer to understand disability in terms of two models: the individual and the social. Models are ways of translating ideas into practice and the idea underpinning the individual model was that of personal tragedy, while the idea behind the social model was that of externally imposed restriction. I do not deny the influence (some positive, some negative) of medicine, charity and welfare in the lives of disabled people but none of these offer a sufficient foundation for building a distinctive model of disability.

For too long, this individual, medicalised model of disability has dominated disability policy and service provision (Oliver 1996a, 1996b). The medical view of disability tends to regard disabled people as 'having something wrong with them' and hence the source of the problem. Despite this, disabled people are widely given a low priority when placed against the competing needs of other groups. This is particularly surprising given that, according to the Government's own figures, disabled

people are a significant minority who make up approximately 15% of the population (Oliver 1996a). It was not until the arrival of the social model that the necessary radical change in direction was outlined.

I want to make three general points about the social model. Firstly, it is an attempt to switch the focus away from the functional limitations of individuals with an impairment on to the problems caused by disabling environments, barriers and cultures. Secondly, it refuses to see specific problems in isolation from the totality of disabling environments: hence the problem of unemployment does not just entail intervention in the social organisation of work and the operation of the labour market but also in areas such as transport, education and culture. Thirdly, endorsement of the social model does not mean that individually based interventions in the lives of disabled people, whether they be medically, rehabilitative, educational or employment based, are of no use or always counter-productive (Oliver 1996b).

From a social model perspective, too much is invested in individually based interventions with ever diminishing returns. As a consequence, modifications to environments tend to be neglected or under resourced despite the greater potential benefits of such investments. To put it simply, providing a barrier free environment is likely to benefit not just those with a mobility impairment but other groups as well (e.g. mothers with prams and pushchairs, porters with trolleys) whereas physical rehabilitation will only benefit those privileged enough to be able to access it. This is not a criticism of rehabilitation *per se*, but more about the efficient use of scarce resources.

Additionally, the traditional voice for disabled people had been the big charities that are still largely run and controlled by non-disabled people. Recent Government initiatives like the establishment of the Disability Rights

Commission (DRC) have done little to change this situation although the number of organisations controlled and run by disabled people has grown steadily at both local and national levels. This trend must be sustained as the voice of disabled people is crucial to delivering on the social model.

### ***From theory to practice***

We can see how this has been applied in examining current welfare to work policies in respect of disabled people. There is universal agreement that disabled people do not have the same access to jobs as the rest of the population. Estimates of the unemployment rates amongst disabled people suggest that they are between two and five times more likely to be unemployed and that this huge discrepancy cannot be accounted for solely on the grounds of impaired performance. However, government policies are, by and large, targeted at equipping impaired individuals for the unchanging world of work rather than changing the way work is carried out in order that more people might access it. Hence, much greater resources are currently spent on employment rehabilitation, training and so on (individual model) rather than on removing the barriers to work or on attempting to prevent the labour market from operating in a non-discriminatory manner (social model).

For example, the Government is promoting disabled people's inclusion in the paid labour market with policies to revise the benefits system, and make radical changes in the operation of the labour market. All these sound like social model solutions to the problem of high unemployment rate amongst disabled people. However, when the government talks about mechanisms to implement these changes, it focuses on two things: a small number of special schemes, and job coaches for individual disabled people. So while the government accepts that the problems are external to disabled people,

its solutions target individual disabled people.

In the broadest sense, the social model of disability is about nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment – whether physical, sensory or intellectual. The barriers disabled people encounter include inaccessible education systems, working environments, inadequate disability benefits, discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities, and the devaluing of disabled people through negative images in the media – films, television and newspapers. Hence, the cultural environment in which we all grow up usually sees impairment as unattractive and unwanted. Consequently, parent's feelings towards, and treatment of, a child born with an impairment are dependent upon what they have learned about disability from the world around them. Moreover, people who acquire impairment later in life have already been immersed in the personal tragedy viewpoint and it is not therefore surprising that many of these individuals find it difficult to know how to respond in any other way.

The social model of disability does not ignore questions and concerns relating to impairment and/or the importance of medical and therapeutic treatments. It acknowledges that in many cases, the suffering associated with disabled lifestyles is due primarily to the lack of medical and other services. It is similarly recognised that for many people coming to terms with the consequences of impairment in a society that devalues disabled people and disabled lifestyles is often a personal tragedy. But the real misfortune is that our society continues to discriminate, exclude and oppress people with impairments viewed and labelled as disabled.



As a consequence, in Britain, there began a remarkable growth in organisations of disabled people in the 1980s, along with the appearance of Disability Equality Training. Furthermore, the social model became the primary means of taking forward the idea of disability equality, across a whole range of trainers and organisations. The next stage in its development came when the Disabled People's Movement, notably the British Council of Organisations of Disabled People (BCODP), adopted the social model. If you read the book by Jane Campbell and myself (Campbell and Oliver 1996) you will see quite clearly that it played a crucial role in enhancing the collective consciousness of disabled people and in the emergence of the Disability Movement.

But it was not just amongst disabled people that the social model idea gained recognition. It gradually became incorporated into the State and there were a number of reports, the first in 1988 was called *A Wider Vision* (DHSS 1988), which advocated the idea of the social model as the way forward in providing services for blind and partially sighted people. Thus, by the 1990s the social model was being colonised by a range of organisations, interests and individuals, some of whom had bitterly opposed its appearance less than 10 years previously.

### ***Criticisms of the social model***

There are five main criticisms of the social model that have come from within the Disability Movement and disability studies. The first of these is that the social model ignores or is unable to deal adequately with the realities of impairment. This is based upon a conceptual misunderstanding because the social model is not about the personal experience of impairment but the collective experience of disablement (Oliver 1996b). This critique has sometimes turned into personal attacks and a few have suggested that it is only fit, white men in wheelchairs who are able to ignore their impairments.

As a severely disabled tetraplegic, who everyday of my life needs to make the necessary arrangements to be able to get up in the morning and go to bed at night and indeed use the toilet, I find such suggestions galling, particularly when they come from non-disabled people or those disabled people who have no idea what it is like to be at the mercy of State services for personal survival, let alone social functioning. Of course, white men in wheelchairs are aware of the limitations that impairments impose, and of course we struggle with the difficulties they create for us. But as I have indicated elsewhere (Oliver 1990), the limitations that our functional impairments impose upon us are an inadequate basis for building a political movement.

A second, related criticism contends that our subjective experiences of the 'pain' of both impairment and disability are ignored by the social model. Again, I find this censure partial and hard to countenance. If I simply focus on my own work, I co-wrote a book on male experiences of spinal cord injury (Oliver et al. 1988) and undertook another study of the experiences of disability and ageing (Zarb and Oliver 1993). More generally, I cannot accept assertions that the social model is not based upon disabled people's experiences. Quite the reverse, it emerged out of the experiences of disabled activists in the 1970s.

The third criticism of the social model states that it is unable to incorporate other social divisions, e.g. 'race', gender, ageing, sexuality and so on. The fact that the social model has not so far adequately integrated these dimensions does not mean that it cannot ever do so. In my view it is not that the social model cannot cope with these issues. Far better, if the critics had spent less of their time criticising the social model for its perceived failures and instead put more effort into attempting to apply it in practice.



A fourth criticism centres on the issue of 'otherness'. From this perspective, it is not the physical and environmental barriers that we face but the way our cultural values position disabled people as 'other'. This viewpoint is buttressed by recent developments in the theory of postmodernism and ideas about representation being crucial to disabled people. It is wrong to assert that, in principle, the social model ignores cultural values. More importantly, at the present time most disabled people in the world live in abject poverty, and do not have enough food and drink, while the two main causes of impairment internationally are war and poverty. As a consequence of this, any attempt to try to move disability politics exclusively into the realm of representation is fundamentally misguided and inappropriate when so many disabled people continue to experience life threatening material deprivation.

The final criticism of the social model is that it is inadequate as a social theory of disablement. Now the problem with this is that I do not think that those of us involved in the early discussions around the social model ever claimed that it was equivalent to a theory of disability. Indeed, most of us explicitly said these theoretical debates still needed to take place (Oliver 1996b). And yet, a recent collection (Corker and French 1998) spends a lot of time in the first and last chapters criticising what are termed 'social model theorists' for their inadequacies before finally acknowledging that the social model is not a theory. It seems superfluous to criticise the social model for not being something that it has never claimed to be.

These criticisms should not be seen merely as academic disputes, however heated and vitriolic they have become at times. They have also been part of the political terrain over which disability activists have fought in the last ten years. There have been those who have been critical of the alleged formal or informal policing that has

supposedly taken place. For example, the journal *Disability and Society* has been accused of only publishing articles on the social model that were ultimately sympathetic to it. However, a count of articles published between the first number in 2000 and the last number in 2002 demonstrates that the Journal published more than twenty papers which sought to criticise, refine, review or even abandon the social model.

There is less dispute that some disability equality trainers, like some racism awareness and sexism awareness trainers, have been over zealous in their promotion of the social model and have perhaps spent their time trying to make non-disabled people feel guilty that they were not disabled. However, that is clearly a problem with the application of the model by some individuals rather than a flaw in the model itself. Further, there is no doubt that the Disability Movement itself has sometimes been over-sensitive about its 'big idea', but that has to be seen in the context of the way in which throughout our history our ideas have been taken by others, used and indeed even claimed for their own. Something like that pattern has occurred with respect to the social model. Speaker after speaker from non-representative organisations *for* disabled people claimed the social model as their own in the Trafalgar Square demonstrations of 1994. Additionally, the Disability Rights Commission established in 1997 by the New Labour Government declares that it is guided in everything it does by the social model of disability.

This has recently led some parts of the Movement to attempt to reclaim the social model, whatever that means. My argument is that we do not have the time, the energy or the resources to reclaim it, even if such a thing was possible. That would reduce disability activism to the kind of intellectual masturbation in which academics sometimes engage. Instead we need to work out and

promote political strategies that are in line with the principles of the social model. Never mind yet more talk about how we might reclaim it, we need to get on and use it. We must not waste the gift that was bestowed upon by those disability activists who were struggling against the oppressive structures that kept disabled people out of society in the 1970s.

### **The social model in action**

For the remainder of this chapter I want to focus on three areas or projects which I have been involved in over the last twenty years that have sought to apply the social model, although I will concentrate on a recent study of its implementation in Birmingham City Council.

The first project was my attempt to reconstruct social work with disabled people in accordance with the social model principles. It was intended to provide a counter to individualised casework that positioned disabled people as tragic victims in need of personalised therapeutic intervention. My book *Social Work with Disabled People* (Oliver 1983) sought to switch social work intervention away from impaired individuals and target the disabling society. Moreover, the British Association of Social Workers adopted it in 1986 as the way ahead for building a relationship between disabled people and social workers. In practice, this failed to materialise and disability issues have remained a poor relation in equal opportunities social work training, and disabled people's needs have ranked very low down the agenda of most social service departments. There is little doubt that the hegemony of the individual model still endures within social work, as in other professions (Oliver and Sapey 1999).

The social model then, has had no real impact on professional practice, and social work has failed to meet disabled people's self-articulated needs. Twenty years

ago, I predicted that if social work was not prepared to change in terms of its practice towards disabled people it would eventually disappear altogether (Oliver 1983). Given the proposed changes by the New Labour Government in respect of modernising social services, it seems likely that that forecast is about to come true. We can probably now announce the death of social work at least in relation to its involvement in the lives of disabled people.

A second illustration of the application of the social model was very evident in research on disability politics undertaken by Jane Campbell and myself. The social model of disability had become the 'big idea' of the Disability Movement. A central reason for its impact was that it provided a shorthand way of linking up the many diverse experiences among people with a whole range of different impairments (Campbell and Oliver 1996). Prior to the late 1970s and early 1980s disabled people's attempts at self-organisation had always floundered on the conflicts between the specific impairments and the different experiences of disablement that they generated.

The social model was a way of getting us all to think about the things we had in common, and the barriers that we all faced. Of course, some of those barriers were impairment specific; for example, blind people might have information barriers, people with mobility restrictions might have access barriers, deaf people communication barriers and so on. But nevertheless the social model became a way in which to link up all of those kinds of experiences and enabled the Movement to develop a collective consciousness that enabled it to expand at a rapid rate throughout the 1980s.

Yet, in the 1990s, independent living and disabled people's rights have emerged as key ideas to sit alongside the social model. This coupled with the increasing

disputes about the meaning of the social model has led some activists, notably Vic Finkelstein, to claim that the Movement has lost its way and needs to return to its roots. What is clear is that as we move into the twenty first century, the social model of disability is no longer the glue that binds the Movement together in the way that it did in the 1980s. Instead, it has been relegated to the back burner, and its radical potential has been put on hold while the disability leadership has become involved in parliamentary campaigns to improve disabled people's rights and to enhance the services necessary to support 'independent living'.

The third social model project that I want to discuss, and the most recent one that I have been involved with, was carried out with Birmingham City Council (Oliver and Bailey 2002). While many local authorities (and indeed other agencies) have signed up to the social model, none has successfully implemented it as the means to providing services to disabled people. There are no blueprints to guide its implementation and there is not a substantial body of experience on how to do it. This is not necessarily a bad thing, however, because the social model is nothing more than a practical tool to facilitate the restructuring of services and hence can be adapted to specific local contexts, needs and circumstances.

In 1996, Birmingham City Council adopted the social model as a guide to service provision for disabled people. However, like many organisations that claim to endorse the social model, when it was reviewed five years later nothing much had happened. In 2001, I was commissioned to provide a report suggesting ways in which the City Council could take forward its renewed commitment to the social model. I worked with a disabled colleague Peter Bailey and conducted a wide range of visits, meetings and consultations.

We concluded that the influence of the social model of disability varied greatly: with evidence of its impact in some areas, but in many others, it was perceived as largely irrelevant, if not flawed. In discussions, it was possible to identify three broad approaches to service provision among providers, what we term humanitarian, compliance, and citizenship.

*(1) The humanitarian approach*

In this perspective, services are provided out of goodwill and the desire to help individuals and groups perceived as less fortunate. This means that a medical model is all-pervasive, with the professional experts in control of service provision, while the disabled person is regarded as 'the problem'. Hence, users are expected to be grateful for receiving these services. A characteristic outcome is that producers think they are doing a good job even though users, when asked, are often critical. Disabled people do not like being patronised or not valued as human beings. As a result, the relationship between service providers and disabled users is characterised by conflict, with a lack of trust, and dissatisfaction with existing services because they are unreliable and inadequate.

As an illustration, the Ring and Ride service has been set up as a way of compensating disabled people for the lack of accessible transport. Thus, the Council funds an alternative service, but control remains firmly with the provider. What is available falls far short of meeting disabled people's needs, and many complain that the service has been set up for second-class citizens, which they feel powerless to change. Another example of the humanitarian approach exists in the provision of residential care places. This is usually arranged out of a genuine desire to help disabled people but with staff again in effective control disabled users fear that the residential 'solution' will be long-term. With little autonomy in how they lead their lives, disabled inmates are at risk of



becoming institutionalised, and invariably end up with a poorer quality of life than they have the right to expect.

*(2) The compliance approach*

From the 'compliance' perspective, government policy and legislation drive service provision. Obviously the Disability Discrimination Act (DDA) 1995 is of prime importance in respect of services to disabled people but earlier legislation such as the Chronically Sick and Disabled Act 1970, the NHS and Community Care Act 1990 and the Direct Payments Act 1996 are also relevant. Despite the stated objectives of such initiatives, producers have typically seen their role as doing the minimum amount required complying with the law or government regulations. Needless to say, service users often feel disgruntled because they do not think that services are being organised according to disabled people's support needs or rights. It is the producers who interpret the laws, rules and regulations, often adopting a check-list, or task-oriented approach, that simply satisfies basic standards and demonstrates little sense of commitment to wider service goals or to a partnership with disabled users. As a result, the compliance approach is characterised by conflict, a denial of entitlements and expectations, inadequate services and low levels of user satisfaction.

An illustration of the compliance approach is provided in the Home Care or Home Support service, where disabled people should receive personal support to maintain an appropriate degree of control, independence and autonomy for users in their own homes. In practice, staff provide a service to help disabled users go to bed at the end of the day, yet they have to fit in with when staff are available to provide such support. As a consequence, the service does not meet users' needs, but they dare not complain for fear of damaging important relationships. Conversely, the providers are so focussed on their problems that they find it hard to see users as equals, or

align themselves with the aim of user empowerment.

### *(3) The citizenship approach*

In this approach, disabled people are regarded as equal citizens with full rights and responsibilities. Three main dimensions are identified:

- (a) Economic: disabled people are seen as contributing members of society as both workers and valued customers or users.
- (b) Political: disabled people are recognised as empowered individuals, and voters, and a powerful, interest group.
- (c) Moral: disabled people are seen as active citizens with all that implies in terms of rights and responsibilities.

Only when all three dimensions are met will the relationship between providers and users of services be a truly harmonious one.

An example of the citizen approach is evident in the direct payments system. It stresses the following points:

- the user makes direct payments to the person of their choice to provide personal support;
- the support worker identifies the disabled person as the person with the power to end the relationship and the income source;
- the support worker identifies with the overall aims of the relationship not specific tasks, like getting someone to bed;
- the user expects the support worker to turn up on time and therefore can take on work and other commitments;
- the user makes the decisions about how they want to be treated by support staff.

A citizenship approach contrasts with traditional practices such as giving discounts to disabled people for some council services, including leisure services like swimming. The basis on which a discount is applied is often lost in history and continued simply because disabled people are relatively poorer as a group.

However, this is the application of a stereotype unthinkable in a 'race' or gender context. An alternative rationale might be that full access to the service is not available to some disabled people. However, this sustains the compensatory culture that has for so long undermined disabled people's struggle for equality. Such compensation is not consistent with the social model or a citizenship approach. What disabled people are seeking is an end to social oppression and discrimination.

We concluded that services for disabled people in Birmingham are still largely provided under the humanitarian and compliance approaches. However, the Council is moving towards a citizenship approach in terms of services to its ethnic minorities and there is no reason why it cannot do the same in respect of disabled people.

### ***Implementing a citizenship approach***

Departmental services in Birmingham had no single driver, and the formal corporate commitment to the social model in 1995 was widely ignored. The Disability Discrimination Act (1995) was having some effect on services but the compliance was mostly fairly limited and partial. It was evident that beyond a generalised commitment to the humanitarian approach, few elected members showed any real commitment to disability issues.

We know that the main disability charities that drove the humanitarian-based disability agenda for so many years had limited aspirations for disabled people. These could be summed up as a need for good medical care, a

comfortable place to live, and to be protected from those that might take advantage of them. More recently the welfare agenda has been driven by professionals, both within charities and the voluntary sector and within the state, and has moved towards a compliance approach. This contrasts starkly with disabled people's agenda that focuses on issues such as employment and social inclusion, independent living and civil rights.

Recently the Government has made it clear that its idea of citizenship encompasses rights and entitlements as well as duties and responsibilities. Thus, disabled people should be given fair and equal opportunities to compete in the labour market. Despite a number of important and innovative initiatives aimed at getting disabled people into the workforce, only 0.8% of the City Council workforce is disabled. In contrast, the Council has set a target of 20% for people from ethnic minority communities. We believe that adopting a firm target and formulating appropriate plans for the employment of disabled people will have a positive impact and help to overcome the poor response rate amongst disabled people when jobs are advertised. Finally, it is important that those disabled employees already in post are afforded opportunities for promotion and advancement equal to that of the rest of the population. This further presumes that disabled people secure an education and training that provides them with the necessary qualifications and skills.

Of course, other factors like race, gender, age and sexuality also have a considerable impact on how disability is experienced. We found little evidence to suggest that service providers or planners are aware of, or sensitive to, the need to recognise such diversity. Again, the only way to ensure that services do not institutionally discriminate against minority groups of disabled people is to consult widely about their needs. While Council departments assured us that they consulted regularly with

users and in a meaningful way, disabled people often told a different story. Some felt that consultation was tokenistic and even where there were well-established user groups, only 'the chosen few' were consulted and this usually resulted in the department concerned implementing policies that it had already decided on.

The social model is incompatible with taking an impairment specific approach to disabled people. However, we did make an exception in the case of deaf people in Birmingham, many of whom do not see themselves as part of a disabled community but as a linguistic minority. This is in line with the way deaf people nationally see themselves and there is considerable pressure on Government to recognise British Sign Language as a language in its own right. That said, the social model of disability recognises that the communication problems faced by deaf people are not because they are unable to speak but because the rest of us do not speak their language.

Whether action will be taken on our report that will improve the lives of disabled people in Birmingham is unknown at this particular time, but it is the only basis on which it can be judged. There is little point in asking whether the social model was an adequate framework for revamping disability services in Birmingham or whether we accurately translated the principles of the social model as recommendations for action. The real test will be in five or ten or fifteen years when it should be possible to determine its impact in improving the lives of disabled people in Birmingham.

## **Conclusion**

Throughout this chapter I have argued that the social model of disability is a practical tool, not a theory, an idea or a concept. Furthermore, I have suggested that too much time has been spent discussing it rather than

attempting to use it to produce social and political change. If we imagine that throughout human history the carpenters and builders of the world had spent their time talking about whether the hammer was an adequate tool for the purpose of building houses, we would still be living in caves or roaming the plains. Finally, I have tried to demonstrate that we do have a hammer in the Disability Movement and that, if properly used, the social model of disability could become the means of achieving justice and freedom for disabled people 'all over this land'.

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