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CONCEPTUALIZING THE SPECIAL NEEDS COMMUNITY THERAPY FROM THREE MAIN ECOSYSTEMIC MODELS

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Abstract:

The authors of this paper have coined the term *special needs community therapists* to describe this unique group of special needs professionals involved in a participatory community-based trans-disciplinary treatment (involving intervention, rehabilitation and/or management) that caters to short-term (acute cases) and long-term (chronic cases) intellectual and developmental disabilities done within a residential context, where the clients (i.e., these individuals are treated as customers who need specialized therapy services) and the therapists live and work together. Community therapy for people with special needs can be provided via two main management systems – clinically based case management (institution-centered) and/or person-centered care management (client-centered) – and several different service models such as standard community treatment with high client-therapist ratios and intensive community treatment where the emphasis is on community involvement and lower client-therapist ratios.

Keywords: community therapy, intellectual and developmental disability, model of disability, special needs, therapeutic community

Introduction

The term *community therapy* (also known as community care or community service therapy) is often associated with therapeutic community living in some kind of a residential care center involving allied health professionals (e.g., occupational therapists, physiotherapists, speech-language therapists, rehabilitation therapists, counselors and social workers) and often includes medical professionals such as nurses and at least one in-house medical officer on duty at any time of the day or week. However, this should not be strictly the case. When the term *special needs* is added to *community therapy*, it involves more than just those medical and allied health professionals. It should also include the special needs or special education professionals, who are often omitted in such care-based therapy. They are the trained or qualified people who understand, are experienced in working with people with special needs ranging from savant and crypto-savant to profoundly disabled and know what to do with such individuals to meet their needs and wants.

We have coined the term *special needs community therapists* to describe this unique group of professionals. According to Lim (2017), special needs community therapy (also known as community therapy for people with special needs) is a participatory community-based trans-disciplinary treatment (involving intervention, rehabilitation and/or management) to short-term (acute cases) and long-term (chronic cases) intellectual and developmental disabilities (see the IDEA 2004 classification of disabilities in Pierangelo & Giuliani, 2007, for detail) done within a residential context, where the clients (we prefer to use this term instead of *patients* because we treat these individuals as our customers) and the therapists live and work together. Community therapy for people with special needs can be provided via two main management systems – clinically based case management (institution-centered) and/or person-centered care management (client-centered) – and several different service models such as standard community treatment with high client-therapist ratios, and intensive community treatment where the emphasis is on community involvement and lower client-therapist ratios (Wykes, Leese, Taylor, & Phelan, 1998).

To better understand what special needs community therapy involves and what it is all about, there is a need to understand the ecosystem of a therapeutic community which forms the sociocultural context where this group of people special needs will be living and/or working with others. The ecosystem (also known as ecological system) will show us how different levels of ecosystem influence these residents with special needs and their interaction with one another as well as with the therapists who are providing this form of care-based therapy for them.

1. The Ecosystem of Therapeutic Community

Briefly, we define an ecosystem as a system or a group of interconnected elements formed by the interaction of a community of individuals with their environment. The theory of ecosystems postulates that anyone encounters different and diverse environments or contexts throughout his/her lifespan that may, in turn, affect his/her behavior in varying degrees. Hence, an ecosystem can be further broken down into five levels (from the lowest to the highest): microsystem, mesosystem, exosystem, microsystem and chronosystem.

In other words, for people with special needs, the therapeutic community where they live, eat, play, work and sleep constitute the context of special needs community. It must be seen as a five-level ecosystem. The first level is the microsystem. It refers to the direct context they have in their lives residing in the therapeutic community home. Their direct contact will be those other residents living together in the same home as well as the therapists working there. In other words, they have direct interactions with these social agents (i.e., other residents and therapists). None of them will be mere recipients of the therapeutic community living experiences they have when interacting with these people in the microsystemic context, but they are also contributing to the socio-emotional construction of such a community.

This first level of ecosystem "*can be further divided into intra-microsystem and inter-microsystem*" (Ng & Chia, 2009, p. 62). The former has to do with the innate or genetically determined abilities of an individual with special needs. The latter concerns with the adaptive-behavioral skills of the individual with special need to function normally in his/her daily life while residing in the therapeutic community. According to Chia (2008), "*[S]ignificant limitations in adaptive behavior may impact his/her daily life and affect the ability to respond to a particular situation or environment*" (p.28). This is one reason why the principles of Universal Design for Living (UDL) and Living Environment (UDLE) must be incorporated into the design of a therapeutic community home for individuals with special needs to cater to the wide range of varying degrees of severity in terms of the capacity (innate competence), ability (acquired competence) and capability (level of performance) of these people.

The second level is the mesosystem. It refers to the connection or relationship between and among immediate contexts (i.e., microsystems) such as working with therapists, eating together with other residents, receiving visitors and residents' family members as well as in kitchen where they learn to cook, at laundry where they wash their clothing and out in the farm where they plant their vegetables, all within the therapeutic community. For instance, if a resident with severe emotional-behavioral disorder feels awkward in the presence of peers or therapists, s/he may resort to withdrawal from other residents/therapists living/working in the therapeutic community.

The third level is the exosystem. This is made up of social contexts that do not contain the individual with special needs but that this individual's experiences in immediate contexts within the therapeutic community (Ng & Chia, 2009). For instance, a socially isolated non-verbal individual with autism has few personal or community-based ties. In turn, it gives a negative impact of a breakdown in exosystemic activities affecting the autistic individual's social interaction with the peers living in the same therapeutic community.

The fourth level is the macrosystem. This ecosystem consists of the values, laws, customs and resources of the wider community in which a therapeutic community co-exists affecting the activities and interaction at all lower or inner ecosystems. The priority that the macrosystem gives to the needs of the residents of the therapeutic community affects the support the receive at lower or inner levels of the ecosystem. At this level, the community therapists play a very important role to ensure that the economic conditions and political decisions, to give just two examples, do not adversely affect the quality of living and therapy services in the therapeutic community.

2. The Three Main Ecosystemic Models for Special Needs Community Therapy

In order for us to know the main or key ecosystemic models that help to define and conceptualize special needs community therapy, we need to be aware of the different models of disability (we shall substitute *disability* with *special needs* because the former sounds more negative while the latter is more neutral) and understand them as tools that have been used to define "*impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs*" (Michigan Disability Rights Coalition, 2017, para.1) of people with special needs.

In our professional view, there are three main ecosystemic models of special needs. They are the medico-therapeutic ecosystem, the socio-jurisprudential ecosystem, and the socio-economic ecosystem (see Figure 2). Briefly, the medico-therapeutic ecosystem consists of rehabilitation model, tragedy/charity model, and expert/professional model; the socio-jurisprudential ecosystem consists of the social model, religious/moral model and rights-based model; and the socio-economic ecosystem consists of customer/empowering model and economic model. Next, we shall discuss each of the three main ecosystemic models more in detail.

They are often treated with skepticism as it is thought they do not reflect a real world, are often incomplete and encourage narrow thinking, and seldom offer detailed guidance for action. However, they are a useful framework in which to gain an understanding of disability issues, and also of the perspective held by those creating and applying the models.

For Models of Disability are essentially devised by people about other people. They provide an insight into the attitudes, conceptions and prejudices of the former and how they impact on the latter. From this, Models reveal the ways in which our society provides or limits access to work, goods, services, economic influence and political power for people with disabilities.

Models are influenced by two fundamental philosophies. The first sees disabled people as dependent upon society. This can result in paternalism, segregation and discrimination. The second perceives disabled people as customers of what society has to offer. This leads to choice, empowerment, equality of human rights, and integration. As we examine the different Models in this and subsequent articles, we will see the degree to which each philosophy has been applied.

We should not see the Models as a series of exclusive options with one superior to or replacing previous sets. Their development and popularity provides us with a continuum on changing social attitudes to disability and where they are at a given time. Models change as society changes. Given this degree of understanding, our future objective should be to develop and operate a cluster of models, which will empower people with disabilities, giving them full and equal rights alongside their fellow citizens.

3. Social Model of Disability

3.1 Definition 1

The Social Model views disability as a consequence of environmental, social and attitudinal barriers that prevent people with impairments from maximum participation in society. It is best summarized in the definition of disability from the Disabled Peoples' International: "*the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others, due to physical or social barriers.*"

Its philosophy originates in US civil rights movement and has been championed by The British Council of Organizations of Disabled People and Rights Now, which calls for self-determination. It is advocated in the UK by leading thinkers such as Dr. Steven Duckworth and Bert Massie and has been the guiding light for the The Local Government Management Board and the establishment of the new Commission for Disabled People.

It is also referred to as the Minority-Group Model of Disability. This argues from a socio-political viewpoint that disability stems from the failure of society to adjust to meet the needs and aspirations of a disabled minority. This presents a radically different perspective on disability issues and parallels the doctrine of those concerned with racial equality that "*racism is a problem of whites from which blacks suffer.*" If the problem lies with society and the environment, then society and environment must change. If a wheelchair user cannot use a bus, the bus must be redesigned.

To support the argument, short-sighted people living in the UK are not classified as disabled. Eye-tests and visual aids – which are either affordable or freely available – means that this impairment does not prevent them participating fully in the life of the community. If, however, they live in a third-world country where such eye-care is not available they are severely disabled. The inability to read and, subsequently learn and gather information would be counted as a severe impairment in any society.

This Model implies that the removal of attitudinal, physical and institutional barriers will improve the lives of disabled people, giving them the same opportunities as others on an equitable basis. Taken to its logical conclusion, there would be no disability within a fully developed society.

The strength of this Model lies in its placing the onus upon society and not the individual. At the same time, it focuses on the needs of the individual whereas the Medical Model uses diagnoses to produce categories of disability, and assumes that people with the same impairment have identical needs and abilities. It also offers positive solutions that have been proved to work in, for example, Canada, Australia and the USA.

The Model faces two challenges. Firstly, as the population gets older the numbers of people with impairments will rise and making it harder for society to adjust. Secondly, its concepts can be difficult to understand, particularly by dedicated professionals in the fields of charities and rehabilitation. These have to be persuaded that their role must change from that of "cure or care" to a less obtrusive one of helping disabled people take control of their own lives.

The Social Model's limitations arise from its failure to emphasis certain aspects of disability. Jenny Morris adds a feminist dimension. "*While environmental barriers and social attitudes are a crucial part of our experience of disability – and do indeed disable us – to suggest that this is all there is, is to deny the personal experience of physical and intellectual restrictions, of illness of the fear of dying*." (Pride against prejudice, 1991) Black disable people face problems of both racial and disability discrimination within a system of service provision designed by white able-bodied people for white disabled people.

3.2 Definition 2

The social model has been developed by disabled people in response to the medical model and the impact it has had on their lives.

Under the social model, disability is caused by the society in which we live and is not the 'fault' of an individual disabled person, or an inevitable consequence of their limitations. Disability is the product of the physical, organizational and attitudinal barriers present within society, which lead to discrimination. The removal of discrimination requires a change of approach and thinking in the way in which society is organized.

The social model takes account of disabled people as part of our economic, environmental and cultural society. The barriers that prevent any individual playing a part in society are the problem, not the individual. Barriers still exist in education, information and communication systems, working environments, health and social support services, transport, housing, public buildings and amenities. The devaluing of disabled people through negative images in the media – films, television and newspapers – also act as a barrier.

The social model has been developed with the aim of removing barriers so that disabled people have the same opportunity as everyone else to determine their own life styles.

A simple example is that of a wheelchair user who has a mobility impairment. He is not actually disabled in an environment where he can use public transport and gain full access to buildings and their facilities in the same way that someone without his impairment would do.

The social model of disability has fundamentally changed the way in which disability is regarded and has had a major impact on anti-discriminatory legislation. However, some disabled people and academics are involved in a re-evaluation of the social model and they argue that the time has come to move beyond this basic position.

4. Medical Model of Disability

4.1 Definition 1

The Medical Model holds that disability results from an individual person’s physical or mental limitations, and is largely unconnected to the social or geographical environments. It is sometimes referred to as the Biological-Inferiority or Functional-Limitation Model.

It is illustrated by the World Health Organization’s (WHO's) definitions, which significantly were devised by doctors:

- Impairment: any loss or abnormality of psychological or anatomical structure or function.
- Disability: any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.

- Handicap: any disadvantage for a given individual, resulting from impairment or a disability that limits or prevents the fulfillment of a role that is normal for that individual. (WHO Classification of Impairments, Disabilities and Handicaps, 1980).

From this, it is easy to see how people with disabilities might become stigmatized as "lacking" or "abnormal".

The Medical Model places the source of the problem within a single impaired person, and concludes that solutions are found by focusing on the individual. A more sophisticated form of the model allows for economic factors, and recognizes that a poor economic climate will adversely affect a disabled person's work opportunities. Even so, it still seeks a solution within the individual by helping him or her overcome personal impairment to cope with a faltering labor market.

In simplest terms, the Medical Model assumes that the first step solution is to find a cure or - to use WHO terminology – make disabled people more "normal". This invariably fails because disabled people are not necessarily sick or cannot be improved by remedial treatment. The only remaining solution is to accept the "abnormality" and provide the necessary care to support the "incurable" impaired person. Policy makers are limited to a range of options based upon a program of rehabilitation, vocational training for employment, income maintenance programs and the provision of aids and equipment.

This Functional-Limitation (Medical) model has dominated the formulation of disability policy for years. Although we should not reject out-of-hand its therapeutic aspects which may cure or alleviate the physical and mental condition of many disabled people, it does not offer a realistic perspective from the viewpoint of disabled people themselves. To begin with, most would reject the concept of being "abnormal". Also, the model imposes a paternalistic approach to problem solving which, although well intentioned, concentrates on "care" and ultimately provides justification for institutionalization and segregation. This restricts disabled people's opportunities to make choices, control their lives and develop their potential.

Finally, the Model fosters existing prejudices in the minds of employers. Because the conditional is "medical", a disabled person will ipso facto be prone to ill health and sick leave, is likely to deteriorate, and will be less productive that work colleagues.

4.2 Definition 2

As medical and scientific knowledge expanded profusely, the doctor and the scientist replaced the priest as custodian of societal values and curing processes. Work and production became commodified, and time became linear. Human worth was then to be determined by perceived work value and profitability; and lifestyles and lives became dictated by the mechanistic practices and institutions of the nation state. Universality replaced particularity, reason replaced mystery, and knowledge and state of the mind superseded the lived experience of the body. 'Normality', then, became determined by the ideal of the white, youthful, able, male body; and otherness to this ideal became hierarchically placed as inferiority. Therefore, difference became redefined as deviance commanding control.

Events of this era were to have a major impact on the lives of those with bodily limitations. The lives of such people were reduced to little more than a medical label, and their futures defined by a medical prognosis. People with disability then became a class requiring physical removal from the "ablebodied" norms of what was developing as an urbanized society. As some commentators note, this was the era when cripples disappeared and disability was created.

As certain groups of people came to be viewed as unproductive and incapable, institutions were established as places with a dual purpose: (a) where such people could be placed whilst other family members could meet workers' obligations; and (b) where such people could be skilled to become productive members of society.

But, with the modern era, there was also an increasing emphasis on scientism and social Darwinism; and this resulted in the roles of special institutions shifting from agents of reform to agents of custody for social control and institutional segregation for those now described as sub-normal. Institutions became the instruments for the facilitation of social death. Through a presumed scientific status, care for people with disability became depoloticized, technicalized and professionalized, predicated on notions of tragedy, burden and helpless dependency.

In the post-industrial and post-enlightenment era, disability, in Western society, has been regarded as an individual affliction predominantly cast within scientific and medical discourses. Therefore, "disability" has come to be defined and signified as a power-neutral, objectively observable attribute or characteristic of an "afflicted" person. According to this model, it is the individual, and not society, who has the problem, and different interventions aim to provide the person with the appropriate skills to rehabilitate or deal with it. However, in a culture, supported by modern Western medicine, and which idealizes the idea that the body can be objectified and controlled, those who cannot control their bodies are seen as failures.

In recent years, and with the influence of normalization principles since the 1970's, the locus of an individualized conceptualization has shifted from the state-run (public) institution to community-based facilities and care. However, the medical perspective of disability remains wedded to the economy, whereby personal capacity and ability are often assessed as incapacity and inability so as to determine a person's eligibility for financial assistance and benefits, and access to personal resources. An economic view narrows the complexity of disability to limitations and restrictions, with implications of whether "flawed" people can be educated or productive.

Lack of access to adequate material resources perpetuates a charity discourse which depicts certain people as in need of help, as objects of pity, as personally tragic, and as dependent and eternal children. It is a discourse of benevolence and altruism; and like with the responses of early Christian communities, this discourse serves a complimentary relationship between perceivably helpless people as instruments for good and virtuous works of mercy and compassion by the more "privileged" members of society.

4.3 Definition 3

The medical model came about as "modern" medicine began to develop in the 19th Century, along with the enhanced role of the physician in society. Since many disabilities have medical origins, people with disabilities were expected to benefit from coming under the direction of the medical profession. Under this model, the problems that are associated with disability are deemed to reside within the individual. In other words, if the individual is "cured" then these problems will not exist. Society has no underlying responsibility to make a "place" for persons with disabilities, since they live in an outsider role waiting to be cured.

The individual with a disability is in the sick role under the medical model. When people are sick, they are excused from the normal obligations of society: going to school, getting a job, taking on family responsibilities, etc. They are also expected to come under the authority of the medical profession in order to get better. Thus, until recently, most disability policy issues have been regarded as health issues, and physicians have been regarded as the primary authorities in this policy area.

One can see the influence of the medical model in disability public policy today, most notably in the Social Security system, in which disability is defined as the inability to work. This is consistent with the role of the person with a disability as sick. It is also the source of enormous problems for persons with disabilities who want to work but who would risk losing all related public benefits, such as health care coverage or access to Personal Assistance Services (for in-home chores and personal functioning), since a person loses one's disability status by going to work.

5. Expert/Professional Model of Disability

The Expert/Professional Model has provided a traditional response to disability issues and can be seen as an offshoot of the Medical Model. Within its framework, professionals follow a process of identifying the impairment and its limitations (using the Medical Model), and taking the necessary action to improve the position of the disabled person. This has tended to produce a system in which an authoritarian, over-active service provider prescribes and acts for a passive client.

This relationship has been described as that of fixer (the professional) and fixee (the client), and clearly contains an inequality that limits collaboration. Although a professional may be caring, the imposition of solutions can be less than benevolent. If the decisions are made by the "expert", the client has no choice and is unable to exercise the basic human right of freedom over his or her own actions. In the extreme, it undermines the client's dignity by removing the ability to participate in the simplest, everyday decisions affecting his or her life. E.g. when underwear needs to be changed or how vegetables are to be cooked.

6. Rights-Based Model of Disability

In more recent times, however, the notion of 'disability' has come to be conceptualized as a socio-political construct within a rights-based discourse. The emphasis has shifted from dependence to independence, as people with disability have sought a political voice, and become politically active against social forces of ableism Disability activists, in engaging in identity politics, have adopted the strategies used by other social movements commanding human and civil rights, against such phenomena as sexism and racism.

7. Tragedy/Charity Model of Disability

The Tragedy/Charity Model depicts disabled people as victims of circumstance, deserving of pity. This and Medical Model are probably the ones most used by non-disabled people to define and explain disability.

Traditionally used by charities in the competitive business of fund-raising, the application of the Tragedy/Charity Model is graphically illustrated in the televised Children in Need appeals in which disabled children are depicted alongside young "victims" of famine, poverty, child abuse and other circumstances. Whilst such appeals raise considerable funds for services and equipment which are not provided by the state, many disabled people find the negative victim-image thoroughly offensive. In fact, Children in Need has been described as "*televisual garbage… oppressive to disabled people*" M. Oliver quoted in C. Donnellan "*Disabilities and Discrimination Issues for the Nineties*" 1982. Some go as far as interpreting the tragic portrayal as a means of maintaining a flow of donations and keeping able-bodied people in work.

The Tragedy/Charity Model is condemned by its critics as disenabling, and the cause of much discrimination. Speaking on the BBC Everyman program The Fifth Gospel (date?), Nabil Shaban said: "*The biggest problem that we, the disabled have, is that you, the non-disabled, are only comfortable when you see us as icons of pity*." Because disabled people are seen as tragic victims, it follows that they need care, are not capable of looking after themselves or managing their own affairs, and need charity in order to survive.

From tragedy and pity stems a culture "care". Although highly praiseworthy in many respects, it carries certain dangers. Numerous charities exist to support and care for people with a particular type of disability, thereby medically classifying, segregating and often – as with the Medical Model – institutionalizing many disabled people. Over 400,000 adults in Great Britain are affected by institutionalization given the choice, many, if not most would opt for community life with adequate support.

The idea of if being recipients of charity lowers the self-esteem of people with disabilities. In the eyes of "pitying" donors, charitable giving carries with it an expectation of gratitude and a set of terms imposed upon the beneficiary. The first is patronizing; the second limiting upon the choices open to disabled people. Also, employers will view disabled people as charitable cases. Rather than address the real issues of creating a workplace conducive to the employment of people with disabilities, employers may conclude that making charitable donations meets social and economic obligations.

This is not to advocate dismantling charities and outlaw caring, charitable acts, which enrich our society and bring badly needed funds. But we do need to educate charity managers and professionals to review the way they operate and ensure that funds are channeled to promote the empowerment of disabled people and their full integration into our society as equal citizens – requiring our respect and not our pity.

8. Religious/Moral Model of Disability

8.1 Definition 1

The Religious Model views disability as a punishment inflicted upon an individual or family by an external force. It can be due to misdemeanors committed by the disabled person, someone in the family or community group, or forbears. Birth conditions can be due to actions committed in a previous reincarnation.

Sometimes the presence of "evil spirits" is used to explain differences in behavior, especially in conditions such as schizophrenia. Acts of exorcism or sacrifice may be performed to expel or placate the negative influence, or recourse made to persecution or even death of the individual who is "different".

In some cases, the disability stigmatizes a whole family, lowering their status or even leading to total social exclusion. Or it can be interpreted as an individual's inability to conform within a family structure. Conversely, it can be seen as necessary affliction to be suffered before some future spiritual reward.

It is an extreme model, which can exist in any society where deprivation is linked to ignorance, fear and prejudice.

8.2 Definition 2

In a Western Judea-Christian society, the roots of understanding bodily difference have been grounded in Biblical references, the consequent responses and impacts of the Christian church, and the effect of the enlightenment project underpinning the modern era. These embodied states were seen as the result of evil spirits, the devil, witchcraft or God's displeasure. Alternatively, such people were also signified as reflecting the "suffering Christ", and were often perceived to be of angelic or beyond-human status to be a blessing for others.

Therefore, themes which embrace notions of sin or sanctity, impurity and wholeness, undesirability and weakness, care and compassion, healing and burden have formed the dominant bases of Western conceptualizations of, and responses to, groups of people who, in a contemporary context, are described as disabled. In the past, various labels have been used for such people. These include crippled, lame, blind, dumb, deaf, mad, feeble, idiot, imbecile, and moron.

In the nomadic and/or agrarian societies of pre-industrialization, when time was cyclic, people perceived with limitations often lived with their families. They were ascribed roles and tasks in line with their capabilities, and which fulfilled the co-operative requirements for corporate survival. Others, though, could not stay with their families. Some were ostracized, and their survival threatened, because of a popular conception that such persons were monsters, and therefore unworthy of human status. Some became homeless and dislocated for other reasons such as poverty or shame. Religious communities, often within the local precincts or parishes, responded to these groups of people in various ways. These included the promotion and seeking of cures by such actions as exorcisms, purging, rituals and so on; or providing care, hospitality and service as acts of mercy and Christian duty to "needy strangers".

However, important changes were to occur with the evolvement of the modern era profoundly influenced by the enlightenment and industrialization. During this time, religious values and modes were challenged by the uprising of reason and rationality.

8. Definition 3

The Moral model is historically the oldest and is less prevalent today. However, there are many cultures that associate disability with sin and shame, and disability is often associated with feelings of guilt, even if such feelings are not overtly based in religious doctrine. For the individual with a disability, this model is particularly burdensome. This model has been associated with shame on the entire family with a member with a disability. Families have hidden away the disabled family member, keeping them out of school and excluded from any chance at having a meaningful role in society. Even in less extreme circumstances, this model has resulted in general social ostracism and self-hatred.

9. Economic Model of Disability

Under this Model, disability is defined by a person's inability to participate in work. It also assesses the degree to which impairment affects an individual's productivity and the economic consequences for the individual, employer and the state. Such consequences include loss of earnings for and payment for assistance by the individual; lower profit margins for the employer; and state welfare payments.

The Economic Model is used primarily by policy makers to assess distribution of benefits to those who are unable to participate fully in work. In recent years, however, the preoccupation with productivity has conflicted with the application of the Medical Model to classify disability to counter fraudulent benefit claims, leading to confusion and a lack of co-ordination in disablement policy.

The challenge facing the Economic Model is how to justify and support, in purely economic terms, a socially desirable policy of increasing participation in employment. Classical economic laws of supply and demand stipulate that an increase in the labor market results in decreased wages. Arguably, extending access to work through equal opportunities reduces an employer's labor costs, but other factors come into play.

The value of labor is based upon its contribution to marginal cost, i.e. the cost of producing the last unit of production. This only works when employees make an equal contribution to marginal cost. However, evidence suggests that disabled employees make a lower contribution than their work colleagues do, resulting in losses in production and lower profits for the employer.

Employers may recognize compensations for any loss in employing less-productive disabled employees through kudos, publicity, customer alignment and expansion arising from their presentations as an organization with community values. However, employers are not generally altruistic and hold the economic viability and operational effectiveness of their organization as higher priorities than demonstrating social awareness. Their economic option is to pay disabled employees less or have the losses met through subsidy.

The problem for the users of Economic Model is one of choice. Which is better: to pay the disabled employee for loss of earnings, or the employer for loss of productivity? The first carries stigma for the disabled person by underlining their inability to match the performance of work colleagues. With the latter, difficulties arise in correctly assessing the correct level of subsidy. The productivity of a disabled employee may well change, as well as the marginal costs of the total workforce.

This leaves one outstanding difficulty for the socially minded economist. How do we achieve an equitable, effective, value for-money distribution of disability related benefits? It is likely that there will be people with disabilities that prevent them from doing working. There will be others whose productivity levels are so low that the tax benefits to the public purse are outweighed by the employment subsidy. In economic terms, these people are unemployable and should be removed from employment to supplementary benefits, saving the expenditure on the subsidy. But is this socially acceptable? This apparent conflict has created ambiguity in agreeing social security goals and has led to stigmatization of disabled people as a burden on public funds rather than partners in the creation of general social prosperity.

Social security benefits are not designed to remove disabled people from poverty. The policy maker needs to balance equity (the right of the individual to self-fulfillment and social participation through work) and efficiency. The true value of the Economic Model is maintaining this balance in the macroeconomic context of trade cycles, inflation, globalization and extraordinary events such as wars.

10. Customer/Empowering Model of Disability

This is the opposite of the Expert Model. Here, the professional is viewed as a service provider to the disabled client and his or her family. The client decides and selects what services they believe are appropriate whilst the service provider acts as consultant, coach and resource provider.

Recent operations of this Model have placed financial resources into the control of the client, who may choose to purchase state or private care or both.

11. Rehabilitation Model of Disability

11.1 Definition 1

This is an offshoot of the medical model, which regards the disability as a deficiency that must be fixed by rehabilitation professional or other helping professional.

11.2 Definition 2

This model is similar to the medical model; it regards the person with a disability as in need of services from a rehabilitation professional who can provide training, therapy, counseling or other services to make up for the deficiency caused by the disability. Historically, it gained acceptance after World War II when many disabled veterans needed to be reintroduced into society. The current Vocational Rehabilitation system is designed according to this model.

Persons with disabilities have been very critical of both the medical model and the rehabilitation model. While medical intervention can be required by the individual at times, it is naive and simplistic to regard the medical system as the appropriate locus for disability related policy matters. Many disabilities and chronic medical conditions will never be cured. Persons with disabilities are quite capable of participating in society, and the practices of confinement and institutionalization that accompany the sick role are simply not acceptable.

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