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Introduction

Health and social care workers need to see people as active partners in decisions, not passive recipients of services, in order to practice person-centred care. In adult social care, assessment should focus on what is important to the person, what life they would like to live and the support required to make this possible. This is because the social model of disability is a good starting point, as it does not assume that disability is a direct result of an impairment. However, it highlights the factors that prevent participation, independence and equality due to environmental, organizational and attitudinal barriers. This essay critically analyses the development, critiques and responses to the model, as well as its implementation in England for assessing adult social care. It states that the model focuses on person-centred practice as it moves away from looking at individual deficits to barriers to health. But it works best together with human rights, supported decision making, awareness of the impacts of impairment, sufficient resources and organizations' accountability.

Part One: Emergence, Development, Critiques and Responses

Earlier models generally focused on the disability of the person. Physical, sensory, cognitive or psychological differences were considered personal defect that needed diagnosis, treatment, rehabilitation or professional management. Medical intervention may be beneficial, but too personalized an intervention might give professionals too much power in determining the nature of needs and solutions. Moreover, it may also lead to paternalism, in which regard, disabled people are perceived as weak, lacking, and unable to run their own affairs.

This interpretation was challenged by the social model which arose from disabled people's demands for change (Oliver, 1990). The main difference it brings to the table is between impairment and disability. The word impairment refers to any difference in the body, senses, thought or mind, whereas the word disability refers to a disadvantage that is a result of inaccessible environments, discriminatory attitudes and inflexible institutions. As per Lawson and Beckett (2021) the model is a shift of responsibility from the person to the society. Mobility is not the only factor that defines disability – a wheelchair user is disabled at a narrow doorway and without lift, if a building does not have one. The barrier is not the only cause of exclusion.

This shift also has a tremendous impact on person centred care. Practitioners should consider what is stopping a person from taking part, and what might make it easier for them to take part. This might be considered in relation to a lack of access to housing, of transport, inflexible regulations governing services, language barriers, poverty and prejudice. The model is for taking independent action, accessibility, co-production, reasonable adjustment, choice and control. They have shared features with person-centred practice as they both focus less on the process of standardization, and both agree that the outcomes should be those that people value themselves (Rivas et al., 2025).

The model has emerged as a result of connections with strengths and human rights based approaches. Strengths-based practice does not focus on deficits only but also takes into account abilities, relationships and community resources (Miller and Mahesh, 2025). Human-rights approaches include enforceable principles of dignity, equality, participation and non-discrimination. Lawson & Beckett (2021) argue that the social and human-rights models are complementary: the former helps to understand how barriers are associated with disability, while the latter helps to identify duties to wield in the response to barriers.

Like all models, however, there is much criticism that leveled at the social model. First, it may give a false perception of separation between impairment and disability. An accessible environment can pose barriers to daily functioning with physical, tiredness, seizures, difficulty breathing or changes in cognition (Shakespeare, 2013). Without taking these experiences into account, practitioners might underestimate the level of health care, rehabilitation, equipment or personal assistance needed. Barriers should be included in a well-balanced assessment, but should not cancel out the effects of impairment.

Secondly, there has been criticism that it has a limited understanding of diversity. Disability meets with ethnicity, gender, poverty, sexuality, age and location. People with similar impairments may consequently experience different barriers. On the other extreme, a person living in a rural area may lack a means of transport and a person from a minority ethnic group may be faced with language issues and the implicit assumptions of the dominant culture. Thirdly, the model might not be easily applicable when there are people who have high communication and decision making needs. Participation may require advocacy, accessible information and/or communication technology and/or additional time. Family members may be able to provide valuable information but should not assume that their opinions are in place of the person.

The criticism is not so incendiary as to be a rejection of the model. Instead, they support the interaction of impairment and flexible understanding of the environment and social inequality.

Together with the relational autonomy and human rights, the social model can contribute to the reduction of medical paternalism and under provision of personal support needs.

Part Two: Application to Policy and Practice

Many of the principles of the social model of disability are reflected in the law and policy of adult social care in England. The Care Act 2014 mandates that local authorities foster wellbeing by engaging the care recipient in assessment, care planning and review (Department of Health and Social Care, 2025). Wellbeing involves having dignity, control in everyday life, relationships, physical and mental health, appropriate housing, and access to work, education and recreation. Thus, assessments must reflect the goals sought by a person, not just whether they are eligible for a specific service. This is a social model approach as practitioners are asked to consider social, environmental and organizational barriers to independence and participation.

The duty to make reasonable adjustments also helps this, which is in the Equality Act 2010. Service providers are not obliged to make systems accessible to disabled people. These might be the provision of home visits, interpreters, easy-read documents, communication aids, additional assessment time or large print or audio materials (Equality and Human Rights Commission, 2022). But, legal obligations do not necessarily mean actual practice. In areas where budgets are limited, caseloads are high and appropriate services are not available, person-centred assessment can be a process of administration instead of a true investigation of what matters to the person (Care Quality Commission, 2023; Skills for Care, 2024).

In practice, the person's own goals, preferred routines and important relationships and activities should become the starting point for assessing them from a social model perspective. The practitioner should then determine what will stop these outcomes from happening. A person with a disability who is a wheelchair user, but struggles to cook their meals or to attend community events, may be initially provided with short personal-care visits. Other factors should also be taken into account in a wider review, such as kitchen adaptations, accessible transport, direct payments, assistive technology and accessibility of local buildings. These options could work better to promote independence than a single allocation of care. However, individual assistance might still be required if the pain or fatigue or another effect caused by the impairment continues to limit daily activities. This shows the social model is helpful, but shouldn't be used so strictly that needs are not being met.

Another key aspect of person centred assessment is accessible communication. A lack of ability to use conventional speech does not mean a lack of preferences or decision making. Practitioners should share information in appropriate formats, consider the use of interpreters and independent advocates as necessary, give time and check understanding. Symonds et al (2020) state that person centred assessment is about communication, building relationships, and negotiating rather than ticking boxes on forms. The standard of the assessment relationship can thus be either a positive or a negative experience for the person, either engagement or decision-making for them.

The social model also provides for strengths-based assessment as it focuses on strengths, personal knowledge, relationships and community resources. This can assist practitioners to identify support that encourages control and participation. The strategy has, however, risks involved. Stronger focus on family, friend, and community relations could result in a shift of responsibility from public services to unpaid carers (Stevens et al., 2024). Family members should not be taken for granted as suitable, available or willing carers. Do not use strengths-based language as an excuse not to provide formal support and/or to underestimate or ignore unmet need.

There are a number of broader barriers to implementation. Rushed and form-led assessments can be the result of staffing shortages or a high caseload. The requirements for eligibility can restrict complex lives to very specific categories and risk-averse organizations might place safety above autonomy. Digital assessment systems can also leave out those who do not have technology or digital skills/supports. In addition, if adapted housing, transport, advocacy/community services are not available, identifying barriers is of limited benefit. This policy-practice disconnect then lies between the language of choice and the limited options.

Imbalances in power should also be accepted. Assessment is made to appear to be collaborative, yet in practice, assessment questions are usually determined by practitioners, the written record is made by practitioners, and the recommendation as to eligibility is likewise made by practitioners. When translated into organizational categories by professional language, a person's account can lose its strength and emphasis on the priorities of the account holder. Personal budgets and direct payments can extend choice but also can shift management responsibilities and jobs onto to individuals. In effective person-centred assessment, it is crucial to discuss

constraints in an honest way, to record disagreements clearly, and to have access to advocacy and practical support to challenge decisions.

The social model generally has a positive effect on the assessment of adult social care, bringing a focus from deficit of the individual to barriers to functioning. Its use may reinforce dignity, participation, control, but only if accompanied by the means of communication, resources, decision-making and services that can address in practice the barriers outlined in policy documents, not just stated.

Part Three: Recommendations

There is a need for co-production of assessment policy between local authorities and disabled people/user-led organizations. It is important that participation is promoted from prioritisation to assessment of outcomes. Information should be made accessible in various forms, and those contributing should be offered some practical help and adequate remuneration for their time and skills. Co-production can enhance assessment policies' relevance and accountability. But this can turn into being tokenistic if the organization seeks input from disabled people and then makes the final decision. Genuine co-production is an element that requires power-sharing and a willingness to listen to the priorities raised by service users.

Second, staff development needs to encompass training around the social and human-rights approaches to disability, accessible communication, intersectionality, supported decision making and positive risk taking. Reflective supervision, observation of practice and frequent case reviews should be utilized to reinforce training. This would support practitioners to question the deficit assumptions and develop their skills to recognize social and environmental barriers. However, if there are problems due to overloaded cases, staffing levels, or lack of services, training is not the solution.

Third, there needs to be greater integration of the assessment pathways for adult social care and housing, transport, health, employment, welfare and voluntary services providers (Thomson and Chatterjee, 2024). When conducting an assessment, practitioners can recognize several obstacles but have little power to deal with them on their own. Individualized contacts (or 'professional contacts', if the term is more appropriate), referral systems that are coordinated, and multi-agency responsibilities that are clear would improve the chances of identified barriers leading to concrete measures.

Fourth, assessment processes and outcomes should be evaluated in terms of quality and effectiveness of person-centred assessment, not simply on how well the processes are followed. Local governments need to consider whether people were meaningfully engaged, provided with information in a suitable form, had more control and had better participation in everyday life. Feedback should be gathered through easily available surveys, interviews, advocacy services and independent reviews.

Lastly, investment in the adult social care workforce is necessary. To have manageable caseloads, continuity and enough time to build trust, to understand the individual situation and to discuss factors in detail. However, if the staffing and resources are insufficient, person centred assessment can become a 'tick in the box' exercise.

Conclusion

The social model of disability is a good basis for person centred adult social care assessment as it focuses on the social, environmental and organizational barriers to participation rather than personal weakness. It promotes accessibility, choice, control and involvement and is included in the Care Act 2014 and the Equality Act 2010.

The model can however be incomplete if applied on its own, not considering the direct impact of impairment and the intersectional inequalities and communication support needs of some. It is also less useful because of the lack of resources, rigid eligibility criteria, service access and staffing challenges. Therefore, human-rights principles and principles of supported decision making and recognition of embodied experience should be integrated into the social model.

Person-centred assessment can only make sense if people are involved in decisions and if organizations are able and willing to tackle the barriers identified.

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