

## Professional regulation and disability equality: challenges for disabled social work students and professionals

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### Abstract

*This article reports on the Disability Rights Commission's Formal Investigation into the impact of regulatory fitness requirements on disabled people studying, qualifying, registering and working in social work. It presents a comprehensive review of legislation, regulation and statutory guidance governing the social work profession, identifying requirements for physical and mental fitness. These fitness descriptors and definitions are often vague and their implications in relation to disability unclear. The implementation of these requirements in practical decision-making within the higher education and employment contexts is explored. Findings point to inconsistent practice with ad hoc procedures involving a multitude of different decision-makers. Evidence submitted by key stakeholder organisations to a formal call for evidence attests to the fact that there are anxieties in relation to how regulatory fitness requirements can or should be implemented in practice. It is argued that generalised fitness requirements are inappropriate and potentially discriminatory. Instead decisions around fitness should be based on the requirements of specific jobs, with consideration of reasonable adjustments where relevant. Public bodies are encouraged to update their policies and procedures, bringing them in line with developments in disability and wider equalities legislation. In addition, a more proactive and positive approach towards the promotion of disability equality is required to shift attitudes.*

**Keywords:** Disability Rights Commission, Formal Investigation, regulatory fitness requirements, disabled people

### Introduction

In September 2007, the Disability Rights Commission (DRC) of Great Britain concluded a year-long Formal Investigation (FI) into the impact of regulatory fitness standards on disabled people studying, qualifying, registering and working in three professions, one of which was social work (DRC, 2007a). The main components of the FI are summarised in the table in Appendix 1 (page 85).

Professional regulation is a means of ensuring standards are maintained and, for a profession like social work, to protect service users or other members of the public

who are often deemed 'vulnerable' in some way. There have been a number of initiatives within Britain to encourage the diversification of workforces in a range of professions (Department of Health, 2000a; Scottish Executive, 2005). However, the interaction between such strategies and existing forms of professional regulation has been under-scrutinised. Yet there is evidence to suggest that elements of professional regulation have the potential to operate in ways that militate against genuinely inclusive workforce strategies.

In relation to disabled people, the DRC handled a number of cases involving professional bodies, employers and higher

education institutions struggling to enforce the law requiring them to regulate entry into professional occupations. Examples included cases relating to social work (see a review of DRC cases by Sin *et al.*, 2006). There are a number of barriers confronting disabled people seeking entry into the social work profession as well as remaining within employment.

This article reports on the types of fitness requirement that exist within the regulation, legislation and statutory guidance governing the social work profession and examines their implications for disabled people. There are a number of regulatory fitness requirements using imprecise definitions and descriptions of physical and mental fitness. Perhaps confusingly, there are significant differences across the countries of Great Britain. In addition, the ways in which such requirements are implemented 'on the ground' are revealed to be variable and inconsistent within both the higher education and employment contexts. This can unwittingly discriminate against disabled people. Some of these experiences from the perspective of disabled people are documented in an independent piece of research conducted for the FI by Stanley *et al.* (2007) and readers are directed to the full report for further details. The article concludes with some implications and recommendations for policy and practice.

### **Social work and disability**

Social work in Great Britain has close association with anti-oppressive and anti-discriminatory theory and practice (Dalrymple & Burke, 1995; Dominelli, 2002; Thompson, 2006). While there may be slight differences in terminology used, the broad approach has been underpinned by a particular orientation: that between social workers and social work clients, particularly a range of vulnerable service users (Wilson & Beresford, 2000). As a caring profession, social work has not as yet paid much attention to disabled people as qualified and

competent professionals. In fact until the mid 1990s relatively little was known about staff, in general, working in social work and social care (Balloch *et al.*, 1999).

There have since been important studies reporting on the diversity and equality issues within the social work and social care workforce. For instance, gender issues within the workforce have been scrutinised by Davey (2002); with McLean (2003a) and Fisher (2006) contributing important but often neglected perspectives on men employed within social work and social care. The ethnic composition of, and racism within, the workforce has also attracted significant attention (e.g. Brockmann *et al.*, 2001; Butt, 2001). There has also been some work on social workers from the perspective of the sexual orientation of staff (McLean, 1998), and also about disabled social workers (McLean, 2001 & 2003b) although there has been more focus upon disabled social work students (Baron *et al.*, 1996; Cooley & Salvaggio, 2002; Crawshaw, 2002; Sapey *et al.*, 2004).

There have also been a number of studies on diversity of the social work student population. Hussein *et al.*'s (2007) study of progression rates among students studying for the DipSW in England found that male students, students from a black and minority ethnic group, and students with a self-reported disability have poorer progression rates.

In general, however, Crisp *et al.*'s (2005) review of literature relating to social work education and training found that few key texts included any or adequate coverage of equality and diversity issues. Coverage, where it exists, was highly variable in depth and quality.

The portrayal and conceptualisation of social work and social workers has pitched vulnerability more often as a characteristic associated with 'clients'. The DRC's FI reported evidence that:

*the culture within ... social work appears to be one where there is discomfort about boundaries between professionals and ... clients being blurred.* (2007a, p.206)

In terms of disability, the approach in many caring professions is still very much in terms of disabled people as the focus of care and caring (Siepel, 1994). The fact that disabled people can be practitioners within caring professions is still not taken seriously enough. As Sapey *et al.*, (2004) noted:

*disabled people are at times expected to remain in the position of being helped, rather than becoming a helper.* (p.15)

Against this context, it is perhaps unsurprising that Sin *et al.* (2006) observed that despite the:

*many claims in the literature...that disabled people are under-represented in social work ... [there is] limited empirical evidence put forward to support these claims.* (pp.10-1)

There is a paucity of monitoring data on disability within the social work profession, and an acknowledgement from some organisations that existing data may be unreliable (Hurstfield *et al.*, 2004). This is in spite of initiatives to encourage a more diverse social care workforce.

As part of the DRC's FI, a formal call for evidence was issued, targeting key organisations within social work, amongst others. As part of the call for evidence, social work regulatory bodies were invited to submit monitoring statistics on disabled employees, students and registrants. Regulatory bodies were additionally asked to provide such information in a way that allowed cross-referencing the 'disability' variable with other key demographic variables such as sex, age and ethnicity.

Submitted responses indicated that none of the regulatory bodies conducted

comprehensive monitoring by disability. Where available, coverage was selective and patchy. Data were not cross-referenced with other key demographic variables therefore inhibiting more detailed analyses. In addition, disability monitoring appears to be a recent phenomenon.

In England the General Social Care Council's figures demonstrated that there were 1,489 disabled qualified social workers comprising 1.95% of all qualified social workers in 2006. The Care Council Wales's data showed that there were 94 disabled social work registrants – 2.15% of social work registrants in Wales in 2006. The Scottish Social Services Council's figures showed that there were 160 disabled registered social workers comprising 2.40% of all registered social workers in Scotland in 2005 (DRC, 2007a, p.208).

### **Disability as risk within the social work profession**

The social work profession is characterised by anxieties about risk, sparked in part by high-profile criminal inquiries. In Britain, for example, the tragic circumstances surrounding the death of Victoria Climbié raised, once more, the issues of risk and regulation.

While gross failures of the system are rare, their impact on public confidence and the construction of professional identities of social workers (both by members of the public and by the profession itself) has been amplified by the media. Regulation regimes have evolved to reflect, to a large extent, influential forces on policy such as public opinion and the market (Hood *et al.*, 2001). Professional regulation has developed to be diagnostic and defensive in an attempt to screen out risks at the earliest possible stages (Tanner, 1998).

The identification and management of risk have become increasingly important and formalised. Alaszewski and Manthorpe

(1998) noted that until the 1980s, little attention was paid to the way in which welfare institutions manage risk. However, risk has now been studied extensively in relation to professional practice (e.g. Alaszewski *et al.*, 1997; Titterton, 2004). Risk assessment and risk management have become *de rigeur* across social care and health professions, with tomes published to guide practitioners through the principles, policies and procedures (e.g. Owen & Pritchard, 1993; Kemshall & Pritchard, 1997).

The conceptualisation of, and discourse around, risk has posited clients and service users as being vulnerable to harm. Regulation, in the context of the social work profession, has developed, in part, to manage perceived risks and to protect the public while ensuring a high quality of service.

Two contrasting conceptualisations of risk apply to disabled people. First, there are risks *to* disabled people as a result of their disability. This is intimately related to the portrayal of disabled people as vulnerable.

Second, disabled people are portrayed *as* risks to themselves and to others. Disability and impairment are understood here as ‘defects’ that have the potential to cause disabled people to bring harm upon themselves, or to have an impaired ability to avoid harm. This ‘defect’ also has the potential to endanger others (DRC, 2007b). In this context, disabled people seeking entry or working within the social work profession can be perceived to be a problem.

The following discussion draws on various sources of evidence generated by the FI to demonstrate how certain methods of managing risk through professional regulation in social work can introduce blanket exclusions that have the potential to bring about disability-related discrimination. In addition, the interaction between key provisions contained within disability

legislation and the implementation of regulatory requirements within the higher education and employment contexts can often be unclear (Sin *et al.*, 2006).

### **Generalised regulatory fitness requirements**

Under the Care Standards Act 2000 (Department of Health, 2000b), the General Social Care Council (GSCC) in England and the Care Council for Wales (CCW) have statutory duties in relation to registering and regulating social care workers (including social workers), and in publishing codes of conduct and practice in relation to them.

In addition to requirements for training, conduct and competence, the Act requires the Councils to be satisfied that an applicant must be of “good character”, as well as “physically and mentally fit to perform the whole or part of the work of persons registered in any part of the register to which his application relates” before he or she can be registered.

For registration as a student, regulation 4(4) states that a student entrant must provide evidence of good character and conduct; and physical and mental fitness to practise as a social worker. This makes no reference to “part of the work of social worker or social care worker” and therefore seems more absolute in its requirement.

For Scotland, on the other hand, the Scottish Social Services Council (SSSC) was established by the Regulation of Care (Scotland) Act 2001 to promote high standards of conduct and practice among social service workers and in their education and training, and to regulate entry to the register. The SSSC is required not to register a person unless satisfied that the applicant meets the statutory requirements of “good character” and competence and meets the Council’s educational and training requirements. This is significantly different to the requirements in England and Wales,

as there is no requirement for physical and mental fitness.

In addition, the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (Scottish Executive, 2002) specify that providers of care services shall not employ any person in the provision of a care service if that person is “not physically and mentally fit for the purposes of the work for which the person is employed in the care service”. This concerns specific work at a specific service, rather than imposing a condition for entry to the profession, training, registration or generally for employment (Ruebain *et al.*, 2006).

### **Fitness decision-making in practice**

The formal call for evidence issued by the FI identified the fact that most of the representatives responding from key stakeholder organisations in social work felt that the regulatory framework was unclear in terms of how disability issues were addressed, and how concerns relating to disabled people were handled. (Sin *et al.*, 2007a). In particular, certain concepts and terminology used to describe and define ‘fitness’ were felt to be vague (Sin, 2007a).

In a separate piece of independent research commissioned as part of the FI, Wray *et al.* (2007) found that, for higher education institutions (HEI), there was:

*a clear link between the regulations, the guidance issued by the regulatory bodies and how decisions are made about fitness ... education providers are following the current guidance laid down by the regulatory bodies. ... Their practice is unlikely to change until the information provided by regulatory bodies is updated. ... Social Work appeared to be at a particular disadvantage in relation to availability of current guidance. (p.11)*

The imprecision in terminology employed to describe and define fitness within the regulation coupled with the lack of clear procedural guidance for those with responsibilities for implementing such requirements in practice can have important implications. For example, in a formal submission to the FI’s call for evidence, a respondent from a higher education institution wrote that:

*These studying, qualifying, registering and working guidelines and frameworks, fail to provide the social work team here at the university with any clear guidance on how to support the students in light of any disability related disclosures, nor does it offer any practical guidance to our placement process or providers in the area of work placements. In fact, the outcome of the registration process is not filtered through effectively to the relevant people at the university.*

There is confusion over what is required in assessing fitness, as well as who should be responsible for such decision-making. This leads to a variety of self-initiated, and often *ad hoc*, management strategies with a number of different outcomes for disabled people.

Structures and procedures for formal and informal fitness assessments in practice are often unclear and inconsistent. Most organisations responsible for implementing fitness requirements rely on a variety of individuals to interpret what the regulations mean when issues relating to disability arise. Responses to the call for evidence demonstrate that organisations relied on a mixture of occupational health (OH) professionals, human resources staff, and admissions staff (Sin *et al.*, 2007a).

Research into decision-making within the higher education context identified that academic staff, OH professionals, human resources staff, university disability officers/advisers, the regulatory body, and

the disabled person him/herself were involved in decision-making around fitness (Wray *et al.*, 2007).

Independent research commissioned in support of the FI on similar decision-making processes within the employment setting also identified the significant involvement of OH professionals. In addition, managers, human resources staff and others were also involved (Fong *et al.*, 2007).

The role of OH professionals in fitness assessments in a range of settings is of interest. Wray *et al.* (2007) found that, at the application stage, 56% of responding HEIs indicated that OH professionals were relied upon to make decisions around an applicant's fitness. That such practice exists and is seemingly rather prevalent is interesting given that the social work profession does not have any explicit requirement contained within its regulatory framework for relying on OH advice. In comparison, while the FI found that reliance on OH was prevalent among HEIs for nursing and for teaching, this was not surprising given that nursing in Britain and teaching in England and Wales have specific regulatory requirements for OH professionals to be consulted in fitness assessments.

Apart from the application stage, Wray *et al.* (2007) additionally found that only around half of responding HEIs with social work programmes stated they had a formal procedure for making decisions regarding fitness of students whilst they were on programmes. That not all HEIs have such procedures in place is cause for concern as the needs of disabled students may change through time. Furthermore, students accepted onto social work programmes may also experience the onset of disability during the programme. There is also the possibility that certain impairments may only be identified after acceptance onto a programme and/or after a programme has commenced.

It is thus unclear how some HEIs handle fitness issues that arise after the application stage. Clarity of procedures and transparency of processes are paramount as disabled students need to be supported on an ongoing basis, particularly if there are changes to needs for reasonable adjustments.

In relation to employment, Fong *et al.* (2007) similarly identified the significant role of OH professionals in fitness assessments. At the pre-employment stage, almost three-quarters of responding social work employers relied on OH professionals in decision-making around fitness. In fact, OH professionals are the single group most relied upon to make such decisions. In comparison, only a quarter of social work employers relied on human resources staff for fitness assessment and less than 5% involved the relevant social services directorate.

The involvement of OH professionals should not, however, be taken to mean that they are deployed consistently 'on the ground'. Indeed, the FI uncovered diverse approaches in how OH professionals operate and how their roles were integrated within the wider structure of an HEI or an employing organisation.

There was a sense of disquiet expressed by some representatives who submitted formal evidence on behalf of key organisations in relation to the perceived potential for uncritical reliance on OH advice. In addition to the obvious risk that disability may be medicalised, there is also the danger that decisions about fitness are delegated to OH professionals who may have little knowledge of exactly what the regulatory frameworks are for the profession. This risk is particularly real in situations where the OH function may not be working in close collaboration with employers or educational institutions over such decisions.

In a formal submission to the FI, an organisation stated that:

*it is not possible to predict the impact of the disability at any one time. ... It is important that each case is treated on its own merits. It is the impact of a condition that needs to be judged in relation to the requirements of a particular post...*

Instead of using information about a person's disability to predict his or her chances of success in completing a course or in securing and retaining employment, the impact of an individual's physical or mental condition needs to be assessed in relation to the requirements of a specific job. The Codes of Practice issued by the DRC provide a number of examples involving the provision of relevant reasonable adjustments in both the higher education and employment contexts (DRC, 2004 & 2007c).

Indeed, the responsibility to consider providing reasonable adjustments is stated clearly within the employment provisions of the Disability Discrimination Act (DDA) which place the responsibility of making decisions about employment with the employer, and not purely with the medical adviser. The DDA Code of Practice states:

*where medical information is available, employers must weigh it up in the context of the actual job, and the capability of the individual. An employer should also consider whether reasonable adjustments could be made in order to overcome any problems which may have been identified as a result of the medical information.* (DRC, 2004, paragraph 6.15)

It is therefore important for OH professionals to work closely with employers and HEIs around reasonable adjustments.

Regardless of who is involved in the processes and structures of fitness

assessment, it is clear that the full responsibility for decision-making was felt to fall squarely on the organisation itself with little support from regulatory bodies (Sin *et al.*, 2007b). This came across very strongly in the formal evidence submitted to the FI by key stakeholder organisations within the profession. There is a distinct sense of anxiety expressed by representatives from these organisations in relation to appropriate methods of reconciling regulatory requirements and professional standards with adequate support for disabled people, as the following extract from the written submission of a representative from an HEI demonstrates:

*The difficulty the social work team are facing with students with dyslexia is how to implement the support they require, are entitled to and receive whilst at university with academic work and balancing this out with the demands of the job and trying to assess students' ability to independently carry out the duties and expectations of their social work role to agency standards.*

### **Wider implications**

Risk management has become the order of the day in a number of professions and there have been concomitant efforts at professionalising workforces and extending regulation. The UK Government has recently proposed that all statutorily-regulated health professionals have 'revalidation' arrangements in place to facilitate professionals periodically demonstrating their continued fitness to practise (Sin & Fong, 2007a). The Government is also considering the regulation of non-medical healthcare professionals, with the aim of standardising regulation, and giving the Council for Healthcare Regulatory Excellence a pivotal role. There are also movements in professionalising the children's services workforce (DfES, 2005).

A cursory look at the regulation around other regulated health professions reveals similarly varied and potentially misleading descriptors of fitness which have a statutory basis (see Sin & Fong, 2007a & 2007b). Similarly, the extent to which the DDA is acknowledged and dealt with in relevant legislation is highly variable. There is thus a real concern that the plethora of legislation, regulation and guidance in a number of other professions may not be DDA-aware nor compliant.

While the DRC's FI focused on the public sector, there is an array of regulations covering care home registration, including fitness standards for managers and employees of care homes. It is of note that none of these registration conditions make any reference to fitness being assessed in a way that demonstrates having due regard to the provider's obligations under the employment provisions of the DDA. This includes conditions for their employees who may be care workers or occasionally social workers. This is significant for disabled people seeking employment in this sector since many providers are small organisations who may have less awareness of their DDA obligations (Ruebain *et al.*, 2006).

## Conclusion

The Chair of the GSCC has recently written to the Minister of State for Health Services asking for the requirement to be '*physically and mentally fit*' to be removed. There has been unease about this requirement for some time and, perhaps partially as a result of the evidence gathered by the DRC's FI, the GSCC now considers the requirements to be an unnecessary and discriminatory barrier (GSCC, 2008).

Public authorities are now required to respond to legislation designed to promote disability equality (DRC, 2006). The disability equality duty (DED) which came into force in December 2006 places a

positive duty on public bodies to have due regard to:

- the need to eliminate unlawful disability discrimination;
- the need to eliminate harassment of disabled people;
- the need to promote equality of opportunity between disabled persons and others;
- the need to take steps to take account of disabled people's disabilities even where that involves treating disabled people more favourably;
- the need to promote positive attitudes towards disabled people; and
- the need to encourage participation of disabled people in public life (see DRC, 2006, p.5).

The DED covers all aspects of public sector activity applying to policy-making, decision-making, service provision, procurement; and to public bodies as employers and as education providers. The implications of the DED are therefore profound, although most public bodies are likely to have underestimated its full significance (Sin, 2007b). All public bodies should therefore update their policies and procedures in light of developments in disability (and wider equality) legislations.

While legislation plays an important role, it needs to be backed up by more proactive and positive approaches towards disability equality that transform cultures and behaviours in a meaningful and sustainable manner throughout the profession (see RADAR, 2007, for case studies of public bodies that have demonstrated good practice in relation to this). This prevents a negative compliance approach towards equality and diversity (O'Conneide, 2003), and shifts people away from the misconception that equality and diversity only applies to various 'minority' groups. Instead, positive approaches towards equality benefit everyone.

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### **Notes on Contributors**

The authors were at the Disability Rights Commission when the work for this paper was conducted. The first author was Head of Information and Research, while the second and third authors were Research Officers. The Disability Rights Commission ceased to exist from 1 October 2007, with its functions absorbed into the new Equality and Human Rights Commission that also has responsibilities for human rights and the other 'equality strands' of race, gender, sexual orientation, age, faith and religion.

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**Appendix 1:** Key evidence-gathering exercises for the Formal Investigation

<b>Evidence strand</b>	<b>Objective</b>	<b>Data and analysis</b>
Regulatory review	Explores the interaction of the statutory/regulatory frameworks with the Disability Discrimination Act (DDA).	<p>Conducted by Ruebain <i>et al.</i> (2006).</p> <p>Relevant legislation, regulations and statutory guidance covering higher education, registration and employment across England, Scotland and Wales.</p> <p>Templates used in the document review to help draw out relevant themes systematically.</p>
Call for evidence from key organisations	Solicits opinions from key stakeholder organisations, including government departments, regulatory bodies, disability organisations, trade unions, and professional bodies about the extent to which the regulatory framework may or may not have an impact on disabled people; and the reasons for this.	<p>A structured instrument soliciting relevant information sent electronically to Chief Executives or Directors of identified organisations.</p> <p>40 organisations responded.</p> <p>Analysis of written-in responses and submitted documents by DRC, undertaken using NVivo 7 via thematic content analysis. Reported in full by Sin <i>et al.</i> (2007a).</p>
Research into decision-making around fitness issues in higher education institutions	Investigates formal and informal decision-making around fitness within higher education institutions.	<p>Conducted by Wray <i>et al.</i> (2007).</p> <p>A two-part research instrument comprising a questionnaire section and a case study section was used.</p> <p>A stratified random sample was generated, and weighted by profession and country. 39 HEIs responded, representing a 39% response rate.</p> <p>Quantitative data analysed using SPSS v14, and qualitative data managed and analysed using NVivo 7. Thematic content analysis conducted on qualitative data.</p>
Research into decision-making around fitness issues in employment	Investigates formal and informal decision-making around fitness within employment context.	<p>Telephone survey of employers conducted by a market research company, Data Captain Ltd.</p> <p>A stratified random sample (weighted by profession and country) drawn from a sampling frame of commercial database of employers in the three professions.</p> <p>69 employers were interviewed, representing a 12.7% response rate. The survey instrument was based on the questionnaire designed by Wray <i>et al.</i> (2007), using the same broad themes.</p> <p>Data were analysed by DRC, using SPSS v14. Reported in full by Fong <i>et al.</i> (2007).</p>

Evidence strand	Objective	Data and analysis
<p>Research into disabled people's disclosure of information about their impairments or health conditions</p>	<p>Investigates the attitudes of disabled students and professionals towards disclosing disability, and identifies conditions that would encourage disclosure.</p>	<p>Conducted by Stanley <i>et al.</i> (2007).</p> <p>A qualitative methodology involving purposive sampling was used to capture the experiences and perceptions of disabled students and professionals.</p> <p>60 qualitative interviews conducted (mostly face-to-face with a few conducted over the telephone and some written accounts submitted). Sample included equal numbers from the three professions, balanced representation of students and practitioners and sufficient representation of the professions in England, Scotland and Wales.</p> <p>Data managed and analysed using NVivo 7, via thematic content analysis.</p>
<p>Inquiry Panel to discuss evidence with influential organisations.</p>	<p>Highlights and probes key issues, and tests emerging ideas for recommendations with key stakeholders.</p>	<p>An Inquiry Panel was convened and chaired by an independent barrister.</p> <p>Panel members included those with expertise in the professions covered by the GFI; disability issues; occupational health; higher education; and regulatory contexts in England, Scotland and Wales.</p> <p>23 witness sessions convened, involving more than 50 key organisations.</p> <p>All oral evidence transcribed and broad themes identified.</p>