Guidance on the Social Model of Disability in Into Work

Contents

1. Introduction

1.1 This guidance aims to provide staff, board members, volunteers, and partners with an introduction to the social model of disability, its history, and how and why it underpins our vision, values, and practice in Into Work.

1.2 The social model of disability originated out of the disability rights movement, it was developed by disabled people, so has lived experience at the heart of the model.

1.3 A recent survey by Evenbreak and YouGov found that 74% of disabled people had not heard of the term 'social model of disability'. This highlights the need for this guidance so we can continue to uphold our awareness of the model in Into Work.

1.4 For ease, this guidance will often use the term "disability" to encapsulate disability, neurodivergence and long-term health conditions. This is for simplicity and is not to minimise the different ways in which disabled people, neurodivergent people, and people living with long-term health conditions experience the social model. The unique experiences of these groups are addressed at different points within this guidance.

1.5 We understand this is a large topic. We do not want anyone to feel intimidated or concerned about getting things wrong, as we recognise this is a learning process.

2. Positioning of Into Work

2.1 It is important for our staff, volunteers, board members, and partners to understand the social model because it shows how it is the barriers created by society that disable people, not the individual's impairment, condition, or difference.

2.2 We can use this understanding to help us to recognise and break down disabling barriers to move towards the Into Work vision of ending the disability employment gap.

2.3 We recognise that the social model is not absolute. It is one approach to thinking about disability, and we understand that disabled people's opinions on the social model will differ.

2.4 Within Into Work we are disabled people ourselves, and/or colleagues and supporters of disabled people.

3. History of the social model of disability

3.1 The social model of disability was developed in the 1970s by disabled academics and activists. This included groups like the Union of Physically Impaired Against Segregation (UPIAS). It resulted from disabled people challenging the accepted views of disability in society.

3.2 In 1976, UPIAS published its Fundamental Principles of Disability. They argued that:

> “It is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are isolated and excluded from society”.
> UPIAS & DA discuss Fundamental Principles of Disability, 1975

3.3 Many of the early social model activists raised awareness of the physical barriers encountered in society.

3.4 Since then, the model has developed to recognise all of the barriers experienced by disabled people, neurodivergent people and people with long-term health conditions.

4. Social model of disability

4.1 The social model argues that there is a difference between 'impairment' and 'disability'. An impairment is an individual’s medical condition or difference.

4.1.1 At Into Work, we are aware the term 'impairment' is not a neutral term; some people will find the term inaccurate and even offensive. However, we include it here as the standard term when discussing the social model and we are locating it within that historical context.

4.2 Disability is the societal impact of having an impairment, condition, or difference. It is a way of describing and categorising the ways in which disabled people are restricted, disadvantaged or excluded from society.

4.3 So, a blind person, a wheelchair user, and an autistic person will share the experience of disability and the disabling barriers in a society that is not organised to meet their differing needs.

5. Barriers

5.1 There are many ways that society disables people. The social model breaks these barriers down into different categories. These categories help us to understand the numerous ways that disabled people are excluded from society.

5.2 This includes **attitudinal**, **physical/environmental** and **communication** barriers:

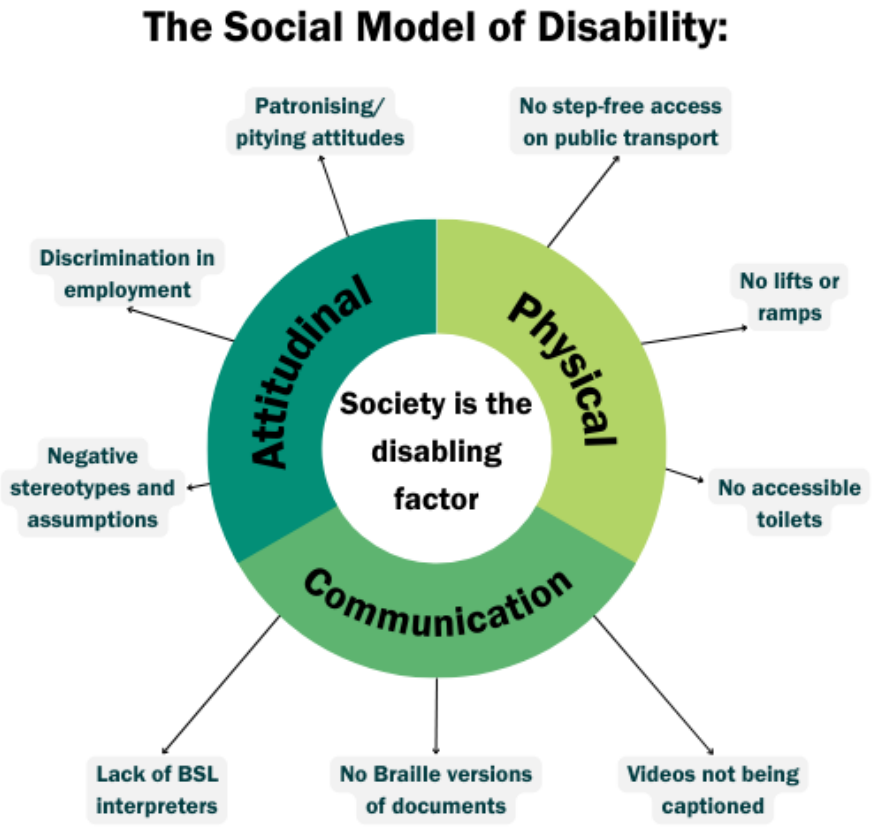


Image by Into Work

5.3 Let's consider examples to see how the social model works in practice:

5.3.1 If a wheelchair user cannot enter a shop because it does not have step-free access, it is **not** because they use a wheelchair. It is because the building has not been designed in an accessible way. It is not the person's impairment that prevents them from going shopping and participating in society, but the **physical barrier** that society has put in their way.

5.3.2 A blind person going to a cinema that does not provide audio descriptions for its films has been prevented from participating in that activity by a **communication barrier.**

5.3.3 An autistic person who 'masks' is changing their behaviour to match neurotypical expectations of what is 'normal' because of pervasive **attitudinal barriers.**

i. Because society is not designed to accommodate neurodivergence, autistic and neurodivergent people may feel pressure to behave a certain way to 'fit in' with a neurotypical environment. This is commonly referred to as 'masking'.

ii. Masking can mean supressing natural autistic responses which are comforting or that can be self-regulating. Adapting behaviour to avoid prejudice can take a lot of energy, which can be exhausting for autistic people, so the attitudinal barrier can have a profound impact.

5.4 By thinking about barriers, the social model helps us to see how disabled people are disadvantaged and helps us think about how we can work to reduce and remove these barriers.

6. Medical model of disability

6.1 The social model was developed to challenge traditional ways of thinking about disability. The medical model of disability was (and in many ways remains) a dominant approach to disability.

6.2 The medical model puts the emphasis on the disabled person's impairments. It looks to make improvements through medical intervention, like surgery or medication. The medical model focuses on a person's impairments as the root cause of disability:

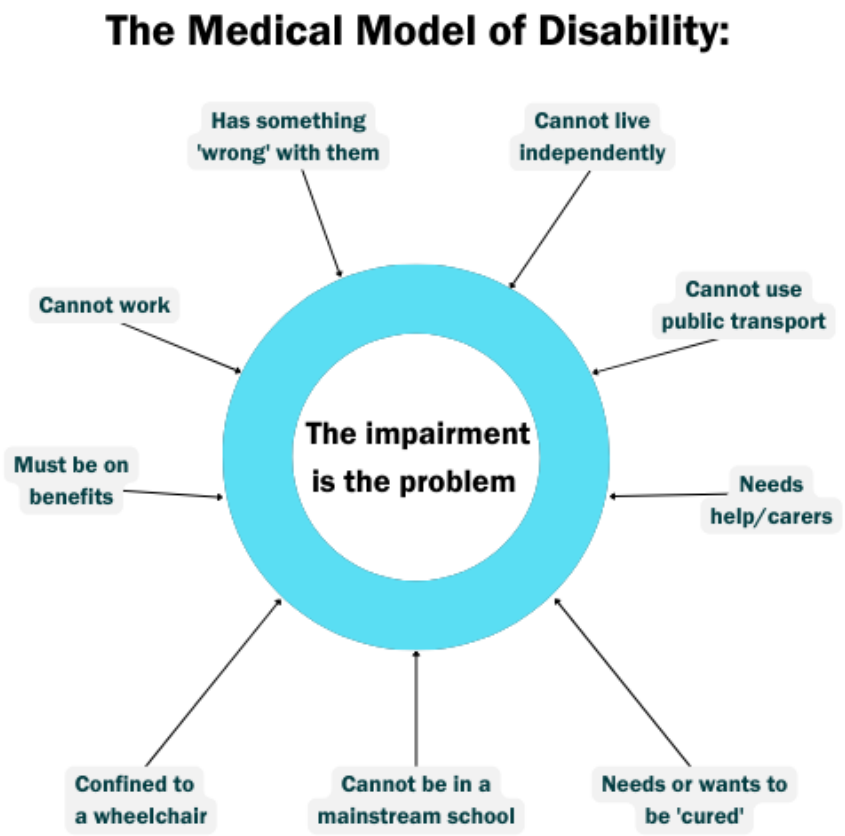


Image by Into Work

6.3 This model has been criticised for focusing on the individual's symptoms and ignoring society's role in disabling people.

6.4 Let's look at our earlier examples through the lens of the medical model:

6.4.1 For the wheelchair user, under the medical model we would look to remove their need to use a wheelchair through surgery or physical therapy, rather than making buildings accessible.

6.4.2 For the autistic person, we would use therapy or other interventions so they can 'fit in' with society's norms and expectations, rather than challenging attitudes so that autism is understood and accepted.

6.5 This is not to say that the social model ignores or minimises the impact that an impairment has on a disabled person's life, or the role that medical intervention can have. Instead, it places the emphasis on changing society to be more inclusive, accommodating, and accessible.

6.6 This short video clip (1 minute, 26 seconds) was made some years ago and is a novel way of illustrating society's barriers and the medical model approach: https://www.youtube.com/watch?v=9s3NZaLhcc4

7. Neurodiversity

7.1 A group of people can be neurodiverse. That can include people who are neurotypical (they have brains that are typically developed) and people who are neurodivergent (they have brains that diverge from a typically developed brain).

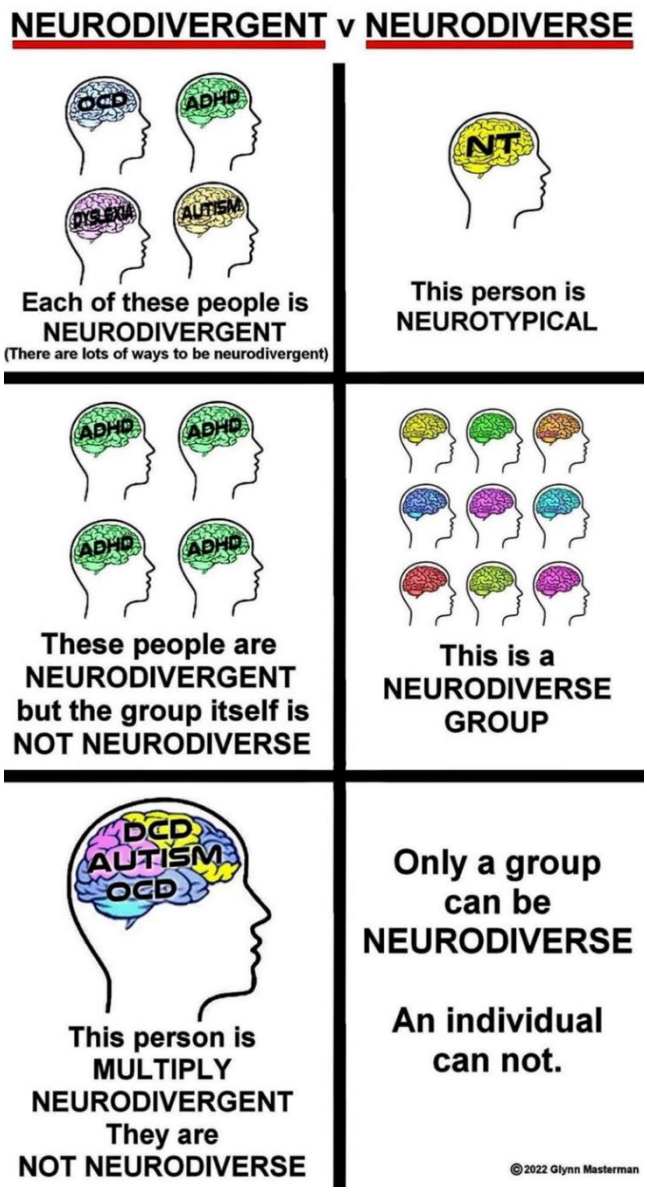


Image by Glynn Masterman

7.2 The term ‘neurodiversity’ was first coined by Judy Singer in the 1990s and is associated with the neurodiversity movement. Like the origins of the social model, the neurodiversity movement emerged from neurodivergent activists. Initially focusing on autism but expanding to include a wider range of neurodivergence, the movement advocates for understanding and acceptance of neurodivergence.

7.3 Because the social model was originally developed with physical disabilities as its primary focus, neurodivergent people have conceptualised how the social model can better apply to them.

7.4 For some, the way that the social model can better apply to autism and neurodivergence more widely is to deviate from using pathologising medical model language that presents neurodivergence as a deficit or a disorder:

> "The primary social barrier to be removed is the negative language and discourse of the autism label, such as deficit and disorder, along with removing subcategories and sublevels”.
> “Exploring how the social model of disability can be re-invigorated for autism: in response to Jonathan Levitt”, Richard Woods, 2017

7.5 Societal barriers being disabling still apply to neurodivergence, but the idea of ‘impairments’ does not necessarily fit. Neurodivergent people can often have ‘spikey profiles’, with areas of high skill and strength alongside other areas of difficulty or difference. And what may present as a difficulty in one setting is a strength in a different setting.

7.6 For example, a person with ADHD may find focusing in a classroom setting difficult, but may thrive in a workplace setting where flexibility and being able to think on your feet are useful skillsets. Here, 'impairment' does not necessarily capture the strengths that neurodivergence can yield.

7.7 Many neurodivergent people still experience impairments in the form of health conditions or co-occurring conditions that come with neurodivergence, but these are not symptomatic of neurodivergence in of themselves:

> "Few (if any) neurodiversity advocates deny that impairments exist in autism [...] health struggles that often come with autism, such as epilepsy and digestive issues. But while these are more common among autistic people than nonautistic (or "neurotypical") people, they aren't actually symptoms of autism.
>
> [...] when we talk about "not pathologizing autism," we don't mean "pretending autistic people don't have impairments." But we also don't assume that neurological and behavioural differences are always problems".
>
> "Clearing Up Some Misconceptions about Neurodiversity", Aiyana Bailin, 2019

8. Non-visible disabilities

8.1 It is important to remember that many disabled people have 'non-visible disabilities'. These are conditions or difference that are not necessarily obvious to onlookers. A wheelchair user or a person with a guide dog can be easily identifiable as a disabled person.

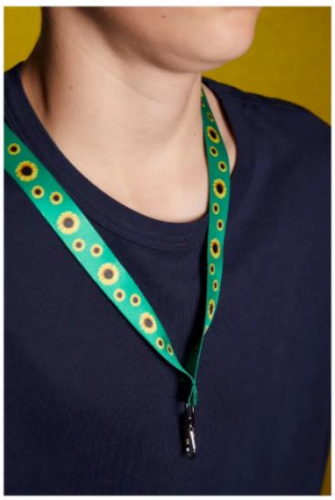
8.2 Examples of non-visible conditions include epilepsy, autism, and chronic pain conditions.

8.3 Some people with non-visible disabilities may have a 'dynamic disability'. Their condition may at times vary in severity for different reasons. Some people may need mobility aids such as walking sticks or wheelchairs only some of the time. Some conditions limit a person's physical and/or cognitive stamina so they may need to reduce their work hours/have flexibility in their work schedule for when their capacity is highest.

8.4 Dynamic disabilities encapsulate the ways that disabled people's needs can vary from day to day. The experience of disability is not always linear or predictable.

8.5 We use the term 'non-visible' as opposed to 'hidden' or 'invisible'. These terms can imply that the person's disability does not exist or that it is being deliberately concealed.

8.6 The sunflower lanyard has become a recognised way to raise awareness and for people to indicate their non-visible disability. They signify that the wearer may need assistance in certain circumstances, such as in shops or on transport.



8.7 Equally, some autistic people may carry a card to provide information and guidance for people. Similar cards exist for a range of disabilities and health conditions.

8.8 The social model still applies to non-visible disabilities. In fact, people with non-visible conditions may face extra barriers because their condition is not obvious to people. They may face questions about using an accessible parking bay if they have been judged to not ‘look’ disabled. This is tied to attitudinal barriers around non-disabled people’s assumptions and expectations about what disability looks like.

9. Language

9.1 As an organisation working to support disabled people, it is important that we use language correctly.

9.2 The following guidance around language is by no means exhaustive, but covers our approach to language as an organisation, and some examples of how language differs between different disabilities, neurodivergences, and health conditions.

9.3 We use identity-first language rather than person-first language. This means instead of saying 'people with disabilities', we say **'disabled people'**. This language is informed by the social model.

9.3.1 We also use 'disabled people' to refer to disabled people collectively, not as 'the disabled'. The same is true of referring to blind and deaf people, not as 'the blind' or 'the deaf'.

9.4 Identity-first language reiterates that disability is an inherent part of the individual's identity, not an addition to it. For an autistic person, autism is a lifelong neurodevelopmental difference which shapes the way they experience and understand the world.

9.5 There are some exceptions to this. We use person-first language when describing people with long-term health conditions and people with learning disabilities. For example, we would say "living with a long-term health condition" like "living with arthritis", or "person who has a learning disability". The term 'people with a learning disability' and the term 'people with an intellectual disability' refers to the same group of

people and depends on the agency and group's preference. Within Into Work we continue to use the term 'people with learning disabilities' as it is the term adopted by the Scottish Commission for People with Learning Disabilities.

9.6 Only conditions which are named after a person are capitalised. So 'Down's syndrome' is capitalised, but 'autism' is not.

9.7 The language that disabled people use to describe themselves is up to them. We need to respect people's individual language preferences.

9.8 An example of this is when an autistic person may self-describe as having Asperger's if this was their original diagnosis and that is what they are comfortable with.

9.9 Within Into Work we no longer use terms like 'Asperger's syndrome' or 'autistic spectrum disorders' as these are outdated and are no longer preferred by the autistic community. We also do not use them because they are not neutral terms, but pathologisisng, medical model language that can reinforce negative stereotypes.

9.10 But within Into Work we would always respect how an individual defines themselves and what they feel most comfortable with.

9.11 If you are ever unsure about what language to use, the best person to ask is the person themself.

9.12 The use of language varies in different parts of the world. In the UK, identity-first language is preferred.

10 Co-production in Into Work

10.1 At Into Work, we employ co-production methods when designing our services. This means that we consult and collaborate with members of the communities we are here to support.

10.2 For example, our Wellbeing+ Advisory Group is made up of current and previous clients who have shared their expertise and visions to co-produce our wellbeing programme.

10.3 Our Autism Works! training for employers was co-produced by an advisory group of autistic people who shared their employment expertise to develop training content. This training is delivered by trainers with lived experience of autism which is making a massive impact to employer participants.

10.4 Co-production originates with disability activists, based on the idea of **"nothing about us without us".** If a service is designed for a disadvantaged or marginalised community without their input, it only serves to alienate that community.

11 The social model in practice in Into Work

11.1 We believe that treating everybody in exactly the same way does not always benefit everyone. Equality to some can mean giving everyone the same resources and opportunities.

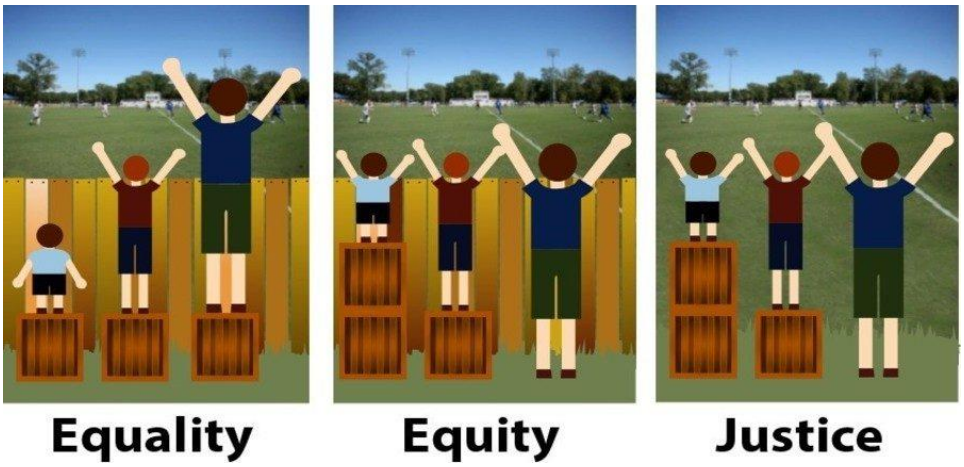


Image from The Inclusion Solution

11.2 Equity recognises that what everyone needs is different as people experience different barriers. It means giving people the resources and opportunities they need to level the playing field and reach an equal outcome. Providing reasonable adjustments in work, for example, helps staff to be equitable. Ultimately, we strive for justice – to address the cause of inequality and remove disabling barriers entirely.

11.3 Because of societal attitudes to disability, many clients lack self-confidence through negative experiences that have caused them to doubt their own belief that they can work. Through our supported employment, wellbeing, and financial inclusion services we help people realise what they have to offer to employers.

11.4 These client focused services work together to help build an individual's capacity to navigate complex systems of employability, health and welfare support and empower people with knowledge to make informed decisions. The Advisory Groups and Wellbeing Workshops facilitate safe spaces for peer support.

11.5 Into Work's supported employment services and training helps employers to have the tools in place to feel more confident in supporting disabled candidates and employees.

11.6 We help employers recognise the value that disabled staff will bring and to understand all the benefits that come from having a more diverse and varied workforce. Jane Hatton, founder of Evenbreak, an accessible job board for disabled candidates, discusses why inclusion is important in her book 'A Dozen Brilliant Reasons to Employ Disabled People':

> "Inclusion is good for the whole business, not just its employees. And it's good for all employees, customers and stakeholders, not just the disabled ones. Employing disabled people isn't an act of charity; we will see that it is a wise business decision".

11.7 This episode of Into Work's Wellbeing+ podcast features a conversation with Jane Hatton discussing the benefits of employing disabled people:
Wellbeing+ Podcast - The Benefits of Employing Disabled People - Into Work

11.8 Our Autism Works! & Neurodiversity Works! training provides employers with an understanding of autism and neurodiversity and some of the adaptations that can help autistic & neurodivergent staff. It also helps employers to realise that it's not just about accommodating disabled staff, but that disabled people offer skillsets that add real value to organisations.

12 Review and feedback

12.1 We hope you have found this guide interesting and helpful. There is so much further reading, research, debate, and documentation on the social model of disability and the concepts that have been introduced in this paper.

12.2 If you would like to provide any feedback to help improve this paper, then please e-mail marketing@intowork.org.uk