

Disability Equality Training (DET) Manual Series No. 2

**PROMOTING DISABILITY EQUALITY**  
**From Theory into Practice**

DET Manual Series:

- No. 1. *Training Them and Us: A Guide to Social Equality for Society*  
Liz Carr, Paul Darke and Kenji Kuno
- No. 2. *Promoting Disability Equality: From Theory into Practice*  
Kevin McLaughlin and Kenji Kuno

Disability Equality Training (DET) Manual Series No. 2

# **PROMOTING DISABILITY EQUALITY**

## **From Theory into Practice**

Kevin McLaughlin  
Kenji Kuno

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*Kenji Kuno*

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Edited by *Kevin McLaughlin*

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## Preface

This is the second book of a series of Disability Equality Training (DET) manuals for DET Trainers. This DET Manual series is published as a part of the Project on Disability, implemented by the Japan International Cooperation Agency (JICA) and the Department of Social Welfare Malaysia. This project, Capacity Building on Social Welfare Services for Disabled People, is implemented to promote the participation and inclusion of disabled people and the mainstreaming of disability issues in development interventions. This project is designed based on the concept of the Social Model of Disability, and DET is taken as one of the key components of the project in addition to the promotion of the Independent Living movement, Supported Employment, and Self-Advocacy of Persons with learning difficulties. In this project, 41 disabled people, from ten countries, namely, Malaysia, Thailand, Singapore, Indonesia, Nepal, Bangladesh, Pakistan, Kyrgyzstan, Maldives, and Afghanistan, have been trained as DET Trainers over the last three years.

I truly hope that this book will provide useful information and ideas on DET. I also welcome comments and suggestions. The above-mentioned project has developed an internet website on DET ([www.detforum.com](http://www.detforum.com)) to provide and exchange information and ideas, so please do visit.

I believe the essential element in working on disability is “SPICE” (just as spices are essential to cook a delicious curry!). So, what is SPICE? It is



the promotion of **S**ocial **P**articipation, **I**nclusion in the **C**ommunity, and **E**mpowerment of all disabled people. So, let's "SPICE up" our work on disability together!

*Kenji Kuno*



## Part One

# Introduction to Disability Equality Training (DET)

Kenji Kuno

This section provides a basic introduction into DET.

### 1. What is DET?

DET	=	Gain Social Model Perspective	+	Develop Personal Proactive Action
DET	=	Contents (Social Model)	+	Process (Facilitated Learning)
DET	≠	Propaganda		

The ultimate goal of DET is to contribute to change society to one that is just, equal and inclusive, where full participation and equality of disabled people are assured.

To realise this aim, DET has two core objectives or components. The first one is to stimulate participants to have an alternative view of disability which examines it as social issue, i.e. Social Model of Disability. Although this is the main part of DET, it is not enough to complete DET. An



equally important component is to facilitate participants to develop their own concrete action plan to break and prevent the building of barriers which hinder participation of disabled people in relation to their own work and lives. Often so-called disability awareness seminars end up only containing the first one. However, such seminars do not facilitate the development of participants' action. DET is neither merely a lecture to add participants' knowledge of disability nor a critique of the government. DET aims to challenge one's sense of values of disability, and to facilitate the development of each participant's proactive activity to break social barriers.

DET values both its contents and process of learning equally. People do not change their sense of values and action by being forced. These would be changed only if and when they became aware of their mistakes and the importance of alternative views and action. Therefore, providing a logical explanation of disability in the contents, self-discovery and reflection opportunity in the learning process are equally important to ensure such changes in participants of DET.

Therefore DET should not be taken as a propaganda tool to impose the Social Model on participants. DET is rather an educational process to assist internal reflection within the participants, to critically (re)consider their standard values on disability.

Disability equality training (DET):

- Take disability as a social issue on rights, discrimination and equality rather than individuals' functional issues.
- Is based on the Social Model of Disability, not the Medical Model.
- Aims to support participants to learn about causes and mechanisms which create disability; and to act to change society to be more just and inclusive, rather than simply raise awareness and change superficial behaviours.
- Avoid using simulation exercise which merely leads to the understanding and emphasis of 'inability' and functional limitations of disabled individuals.

### *Difference between DET and DAT*

DAT = What disabled people cannot do → how to help

DET = Why disabled people are discriminated → how to break barriers

DET is different from the traditionally practised disability awareness approach, so-called Disability Awareness Training (DAT), which usually utilises impairment simulation exercises as its main tool. A fundamental difference of these two types of training is that DAT focuses on the functional aspect of disabled people, i.e. what disabled people cannot do, whereas DET deals with disability as social discrimination and inequality. DAT was developed based on the concept of the Medical Model of Disability which regards impairments as the causes of various issues faced by disabled people. On the other hand, DET is based on the Social Model of Disability which regards disabling social institutions as the main cause of issues which are faced by disabled people.

DAT aims merely to teach participants how to help disabled people when they are in trouble. It does not pay much attention to the reasons why they are facing such problems and troubles. On the other hand, DET aims to facilitate participants to learn why such barriers are made, and how to break or to prevent the creation of such disabling social institutions and infrastructures.

Another key difference is the position of participants in each training course. In DAT, participants are considered as having a neutral position, with no direct relationship to the disability issues; “bona fide third person.” This individual would wish to learn how to help disabled people because disability is perceived as an issue of functional limitation or inabilities in the framework of the Medical Model, which is the theoretical basis of DAT. On the other hand, participants of DET are expected to identify themselves as the oppressor or discriminator, contributing to create a disabling society with or without intention although this is mainly due to ignorance and indifference of the issues and needs of disabled people.

However, DET also emphasises the transformation from such a ‘victimiser’ position to one of a ‘change agent’ to reform society to be more inclusive by supporting the development of their own action plan through their own will and power.

	DAT	DET
Purpose	Understand functional limitation and physical barriers (what cannot) Change behaviour	Understand causes of inequality and discrimination Take proactive action to change society
Understanding of disability	Functional limitations	Discrimination, inequality, social exclusion, participation restriction
Model of disability	Medical Model	Social Model
Issues take similar approach	Aging	Gender, racial minority, HIV/AIDS
Methods (Approach)	Simulation exercise (experience inability)	Facilitated learning, role play/discussion on inequality and discrimination, root cause analysis
Participants	Neutral	Discriminator and change agent
Facilitator/trainer	Medical/welfare professionals	Disabled people

DET pays more attention to the question of why such disabling barriers are made rather than simply identify and make a list of such barriers; “why” you need to do rather than “what” you need to do. A slogan ‘Let’s help disabled people’, does not contribute to the breakdown of disabling barriers. It may rather contribute to the maintenance of such institutional barriers by encouraging paternalistic attitudes and by putting attention to the real cause of disability aside.

***Teach ‘Etiquette’ (Reaction) or Facilitate Proactive Action for Social Change***

Reaction = maintain barriers

Proactive Action = prevent and break barriers → social change

It is useful to know how to assist or help disabled people when required, which is sometimes referred to as ‘etiquette’ towards disabled people. However, if people are satisfied with this, it will not lead to social change.

Without doubt, it is important to lend a hand when disabled people need assistance. However, although such a reaction helps disabled people to climb ‘that’ step, it can never break this or other barriers in society. DET ultimately aims to make participants aware of their own discriminative ignorance and indifference which directly or indirectly contribute to the construction of social barriers. In order to realise an inclusive society, it is crucial that participants examine the causes of barriers and develop their own proactive action to prevent and break such disabling barriers in their immediate daily lives.

“If you see a baby drowning, you jump in to save it: and if you see a second and a third you do the same. Soon you are so busy saving drowning babies you never look up to see there is someone there throwing these babies in the river.” (Wayne Eltwood, cited in Korten, D. (1990), *Four Generations of NGOs*. Search News Oct/Dec 1990, p. 11)

### *Limitation of Simulation Exercises*

Simulation exercises emphasise:

- A functional aspect, NOT a social one
- Inability of individuals, NOT capability
- What is a barrier, NOT why it is made

Simulation exercises e.g. placing non-disabled people in wheelchairs or blindfolding them to experience moving around, only illustrate the experience of functional difficulties, and not the experience of inequality or discrimination resulting from an exclusive society. Emphasis on such experiences may limit understanding of disability in functional aspects and make it difficult to be aware of disability as an issue of rights and equality.

Furthermore, simulation exercises provide only an experience of instant, sudden impairment which usually leads to inability and disorientation. These emphasise what people cannot do if they suddenly have these impairments. This may create negative connotations around disabled people, as being un-able or less-able, although this is certainly not the case for the many who lead 'capable', independent lives.

It is true that simulation exercises can be used to experience physical barriers in society, such as steps and stairs. However, simulation exercises are often used only to identify what a 'barrier' is; and end up by simply teaching participants how to help others climb up the steps, or how to guide a blind person. DET emphasises the importance of examining the causes why such barriers are made, and facilitates action to break them and prevent their creation. Limitations of simulation exercises are also discussed in articles in footnotes.<sup>1</sup>

<sup>1</sup> French, S. (1992). "Simulation Exercises in Disability Awareness Training: A Critique." *Disability & Society* 7(3): 257-266. Kiger, G. (1992). "Disability Simulations: Logical, Methodological and Ethical Issues." *Disability & Society* 7(1): 71-78.

***Why the Social Model?***

Social Model = Explain disability as discrimination

Only the Social Model of Disability can logically explain disability as discrimination, oppression and social exclusion towards disabled people. It also elucidates various social barriers which restrict the mainstream participation of disabled people.

The Medical Model of Disability has two core features. Firstly, it distinguishes people as either so called 'normal' or 'abnormal' (i.e. people with impairments) by setting a standard to distinguish people into these two groups in terms of physical condition. Since it defines 'normal' as an appropriate condition/being, it therefore regards disabled people as inappropriate and inferior beings. Secondly, disabled people are expected to become 'normal', and 'rehabilitation' (in narrow sense, therapy) is regarded as the sole and right path to this functional 'normality'.

On the other hand, the Social Model of Disability has alternative core notions. It makes it explicit that the functional condition of people is diverse; and as a fact, not everyone can become so called 'normal' in terms of physical function even after ten or twenty years of 'rehabilitation' (therapy). Therefore, the only appropriate approach to realise full participation of all disabled people is the removal of the barriers which hinder participation of disabled people in our society (Figure 1).

***Why an Action Plan?***

"I know" → "I do"  
 Reaction → Proactive action  
 Sense of guilt → Change agent

There are three main reasons why 'Action Plan Making' is an indispensable component of DET. First, DET aims not only to facilitate participants to understand disability from the Social Model perspective but also to



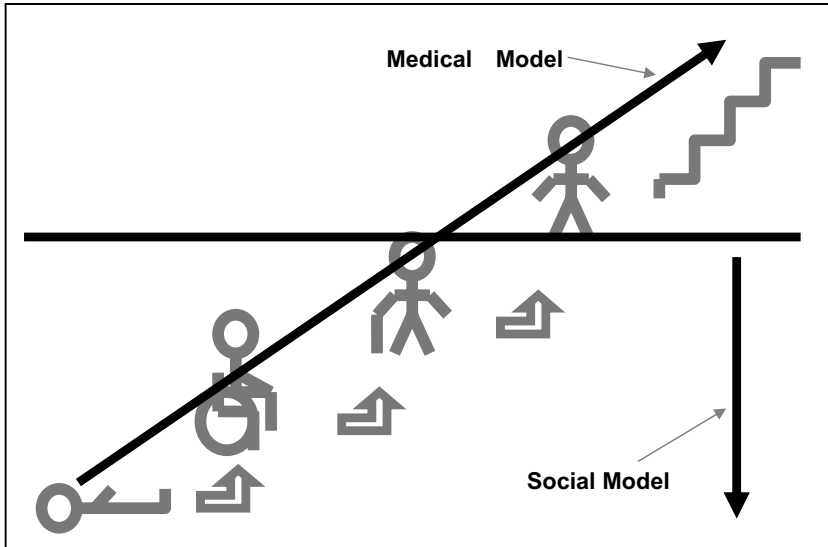


Figure 1: The Medical Model and the Social Model of Disability

facilitate them to be a change agent in the creation of a just and inclusive society. ‘I know’ is not enough. If action plan making is not properly included, many are left feeling: “Now I understand what disability is, but I do not know what to do or how,” “I think the government should take necessary action (not me, it is not my business).” The ultimate purpose of DET is to realise a just and equal society for all, not only to increase an individual’s knowledge and information on disability.

‘Knowing’ is not enough. We need to act. But what does DET expect people to do after the training? That is the second point. DET expects participants to take steps to think and take ‘proactive action’ to break various barriers found daily in their own lives, not just to react to lend disabled people a hand at steps or at a pedestrian crossing. The environment, situation and ability of each participant are different and there is not one ready made action plan to suit everyone. Each person has to make his own action plan to break disabling barriers. This process helps participants to absolve the theory and concept of the Social Model they have learnt into their real life situations.

Similar to the other types of training on discrimination, non-disabled participants of DET who correctly understand disability may feel a sense of guilt and identify themselves as oppressors to disabled people due to their discriminatory ignorance and indifference. In addition to this, they may feel frustration for not being able to resolve such feeling constructively. Making action plans helps participants to transform themselves from oppressors to active change agents by developing their own concrete and achievable action plans.

## 2. Who is a DET Trainer?

DET trainer = Experience + Understanding + Training and  
of Disability of Social Model facilitation skill

DET trainer = Expert on disability education

Only people who have experience of disability, understand the Social Model of Disability and have proper training and facilitation skills can become DET trainers.

Having one's own experience of disability, i.e. the experience of discrimination and social exclusion as outlined in the Social Model, is the most indispensable requisite to be a DET trainer, yet it is not enough. It is also essential to be able to use the Social Model perspective to explain such experience logically and to design and deliver educational processes to participants of a variety of ages and backgrounds. Therefore, the two core components of training of trainers (TOT) of DET are the Social Model of Disability and training skills (e.g. facilitation and presentation). DET takes facilitated and participatory learning approaches. It requires trainers to have a proper set of facilitation and presentation skills.

There is no official qualification system of DET trainer even in the UK. Several organisations run their own training courses to train DET trainers. There are ongoing discussions about 'non-disabled DET trainers'. Some suggest that non-disabled people can be DET trainers, although the majority believe DET trainers should be disabled people.

### 3. Who Should Participate in DET?

DET is for everyone

DET is for : non-disabled people = facilitate proactive action to break barriers

: disabled people = empowerment

DET is for everyone. DET enables non-disabled people to gain the Social Model perspective and develop proactive actions to break various barriers, so they contribute to the creation of a better society for everyone. Through its alternative logical theory on disability, DET also provides an empowerment process for disabled people to overcome their internalisation of non-disabled peoples' discriminative sense of values.

### 4. DET Course Programme

Purpose: Identify disabling barriers + proactive action

Length: 1/2 – 2 days

Methods: Facilitated and participatory learning

Contents: Social Model of Disability

#### *Purpose*

DET has two essential aims. The first is to stimulate an alternative view of disability in participants which examines it as a social issue, i.e. to gain the Social Model perspective on disability. The second is to facilitate development of participants' own proactive action to break social barriers based on the Social Model of Disability.

#### *Course Length*

A minimum of two days is suggested to run an effective DET course. A follow-up session is also recommended after a certain period to

support and monitor the implementation of action plans by participants. However, in practice, a half-day to one-day course is common for a DET programme.

### *Methods*

DET takes facilitated and participatory learning approaches as its framework of methods. These aim to facilitate the self-discovery process, leading to the change of one's own action. Therefore, various approaches and tools to stimulate such learning are used in DET, e.g. role-play, discussion, activities, workshops and games. The box below explains these differences of impact in the learning process. Try to put verbs in the brackets. Answers are at footnote.<sup>2</sup>

If I <b>HEAR</b> it,	If I ( A1 ) it,	If I ( B1 ) it,	If I ( C1 ) it,
I <b>FORGET</b> it.	I ( A2 ) it.	I ( B2 ) it.	I ( C2 ) it.

Cited from David Werner & Bill Bower (1982) Helping Health Workers Learn, Hesperian Foundation, Palo Alto (Part Two-1).

### *Contents*

There is no standardisation in the content of DET courses. All contents of DET are made to assist participants to gain the Social Model perspective on disability and to encourage them to become change agents in the realisation of an inclusive society.

However, the concrete content of each DET course has to be redesigned each time to suit the needs, type and number of participants. Theoretical explanations of the Social Model of Disability in contrast to the Medical Model may be the main content for rehabilitation professionals such as physiotherapists, whereas activities and games to identify social barriers may be more effective for schoolchildren.

<sup>2</sup> A1 (see), A2 (remember); B1(do), B2 (know); C1 (discover), C2 (use).

## *Typical Contents of DET*

### *Disabling Barriers*

An opportunity for participants to explore what 'disability' means in terms of the attitudinal, environmental and institutional barriers experienced by all disabled people e.g. negative attitudes, lack of access, discrimination in transport, housing and other services.

### *Social vs Medical Model of Disability*

In order to understand the processes that result in inequality, discrimination and 'disability', disabled people have redefined disability using their direct experience as the basis for the Social Model of Disability. One of the first and ongoing task of an equality trainer is to move people away from the traditional Medical Model of Disability to the social approach.

### *Self-Organisation of Disabled People*

The history of the Disabled People's Movement, the difference between 'of' and 'for' organisations, and topical issues and campaigns.

### *Terminology*

Words and phrases used to describe disabled people and what impact these have on attitudes to and the lives of disabled people. It is essential that participants explore their understanding of language and the images and ideas it holds for them – it is difficult to separate language from ideas and images.

### *Rights and Equal Opportunities*

Using the Social Model, it is clear where discrimination takes place and what measures need to be taken to eradicate it. Disability is an equality and rights issue – the Social Model acknowledges that it is

not the individuals' problem but the failure of society to recognise the rights of disabled people which causes inequality.

### *Oppression*

To recognise that disabled people may experience multiple oppressions and that by understanding disability from a Social Model context, disabled people can make links with other groups whose biology has been used to justify their exclusion e.g. black people, women, gay men and lesbians.

### *Stereotypes and Imagery of Disabled People*

The image of disabled people in society, how they are viewed, and portrayed in the media, and in particular, charity representations of disability should be balanced by a more accurate picture of disability as illustrated by arts, writing, verse, photography and music of disabled people themselves.

### *Current Disability Issues*

It is important to be able to bring current issues of importance and relevance to the awareness of participants, not least to illustrate the relevance and importance of DET to real life and the daily experiences of disabled people.

### *Action Planning for Change*

To give an opportunity for participants to consider how their attitudes, actions and work practices can be easily altered to reduce discrimination and barriers towards disabled people.

Additional topics may include independent living, inclusive education and employment issues.

(Developed by Liz Carr and Paul Darke)

**Example of DET Course: Half-Day DET Course**

<i>Period:</i>	<i>Schedule:</i>	
Half-day	Time	Content
<i>Aim:</i>	09.30	Introduction and Welcome
– To examine the barriers that disabled people experience from a social as opposed to a Medical Model of Disability	09.45	Disability means ...? A chance to explore how much we really know about disability and disabled people
	10.45	Coffee
– To develop a practical understanding of disabling and empowering language surrounding disabled people.	11.00	Disabling Barriers / Enabling Solutions A workshop highlighting the barriers disabled people encounter with an opportunity to discuss solutions and explore the difference between the traditional view of disability – the Medical Model and the Social Model
	12.00	Language – Does it matter? An opportunity to discuss the importance of terminology and to explore the difference between words used to describe disabled people and their experience
– To identify opportunities and responsibility for individual and organisational change	12.30	A Change for the Better A chance for participants to put today's learning into practice
	01.00	Farewell

(Developed by Liz Carr and Paul Darke)

**5. Conclusion**

Most people's perception of disabled people is strongly influenced by the notion of the Medical Model which is strongly rooted and connected

to capitalism and meritocracy which dominate values in current world society. Therefore, it is not merely a 'model', but an intrinsic part of fundamental standard values, impossible to change by a mere half or one-day DET course. What DET can do is to provide an opportunity for participants to start to think critically of disability and to view their own sense of values from an alternative perspective. It can facilitate them to continue thinking, by posing problems and providing tools to examine disability and the issues faced by disabled people.



## Part Two

# DET Manual

Kevin McLaughlin

### **Introduction**

This part of the book was originally compiled by Kevin McLaughlin and Lucia McLaughlin as a manual/resource for the 1st trainers' training course on Disability Equality Training (DET), which was organised by the Japan International Cooperation Agency (JICA) in conjunction with the Department of Social Welfare, Malaysia in 2005.

It should be noted that the exercises used were intended as a guide on how to deliver a DET session and not intended to be prescriptive. Instead, participants of the course were encouraged to help design new materials more suited to their geographical region.

Some of the material in this manual was previously produced by the Arts Council of Northern Ireland and compiled by Kevin McLaughlin as a document, "Towards Inclusion".

Other material was drawn from a training session delivered by Susan Hemmings to disabled people in Northern Ireland as part of a project to introduce the concept of DET. We are extremely grateful to Susan for her kind permission to use this material.

Section One outlines a course timetable, aims, objectives and exercises to generate debate and discussion around general perceptions of disability, language and terminology, a definition of disability and a comparison between the Medical and Social Models of disability. This section has been written with trainer notes to facilitate its use. The participant handouts

referred to in this section have been incorporated into a workbook in Section Two.

The Disability Rights Commission has produced a video entitled “Talk” which can be used in conjunction with this training manual to highlight the discrimination issues covered.

## **DET Session Outline**

### ***Aim***

To enable staff to develop an understanding of disability that is based on the Social Model of Disability and to identify areas within their organisation/venue that could be changed to promote the participation of disabled people.

### ***Objectives***

- To identify language which is offensive to disabled people and to use more acceptable terms.
- To begin to question and challenge attitudes and levels of awareness regarding disability.
- To critically examine the Medical Model of Disability and to introduce the Social Model of Disability.
- To identify areas for change and to develop an action plan for implementing change.

### ***Timetable of DET***

<i>Time</i>	<i>Contents</i>
10:00	Famous People Exercise Disability Awareness / Equality Training Language and Terminology Attitudes and Awareness
11:15	Break
11.30	Medical / Social Model Action for Change Evaluation
13:00	Finish

## Section One: Trainer's Notes

### *Introduction*

(Handout: Aims and Objectives)

You need to:

Introduce yourself – explain that you will be facilitating the day's workshops. You will also explain that your role is not as a trainer but that you will be guiding the process and ensuring that everyone is involved in discussion of the issues.

Outline the aim and objectives of the training session – give out 'Handout: Aims and Objectives'. At this point you can also explain the timetable and style of training, for example, small group work, feedback. It may also be important to highlight any practical issues such as toilet facilities and fire evacuation procedures.

Introduce participants – this can be carried out as an initial exercise. Ask participants to work in pairs. Get them to choose someone they do not know and to share the following:

- Your name
- Where you are from
- What work/community activity do you do
- One unusual thing about you

Then in the full group, get everyone to introduce the person they spoke to.

Draw up a course agreement – this is important as it sets the ground rules for the way the group will operate during the training session. Practical issues such as smoking, arriving and starting on time, as well as issues of confidentiality, respect for each other and how disagreements or differences of opinion are dealt with need to be agreed here. All of this needs to be written up on flip chart paper and displayed on the wall throughout the training workshop. You may also need to consider the possibility of reviewing the agreement and how this is agreed.

Practical Issues:

- Comfort breaks
- Tea breaks
- Lunch
- Finishing time

***Exercise 1: Famous People Exercise***

(Handout Ex. 1)

You need to:

- Split participants in pairs.
- Ask them to go through the list of names of famous people and identify which of those listed are disabled.
- Have participants explain, if they are aware, the impairment of the disabled person.
- Conduct a feedback session with participants.
- Explain that you will be developing a definition of disability later in the training session that will be different from the impairment model.

This exercise is based on one devised by Barbara Lisicki and has a dual purpose:

- It is a good way of breaking the ice and allows the tutor to gauge the levels of awareness among the participants about disability issues.
- It enables the trainer to explain that later in the training session s/he will be introducing a definition that goes beyond the impairment (medical model of disability).

Answer: Famous People Exercise

---

Julius Caesar	Epilepsy
John Cleese	Mental health problems
Bill Clinton	Hearing impairment
Tom Cruise	Dyslexia
Daniel Day Lewis	Mental health problems
Albert Einstein	Dyslexia
Stephen Hawking	Motor neurone disease
Steve Redgrave	Dyslexia/diabetes
Christopher Reeve	Spinal injury
Franklin Delano Roosevelt	Polio
Vincent Van Gogh	Mental health problems
Stevie Wonder	Blindness

---

***Exercise 2: DET vs Disability Awareness Training (DAT)***

(Handout Ex. 2.1 and Ex. 2.2)

*Aim*

To inform participants of differences between disability awareness training and disability equality training.

Put up a prepared flip chart showing the differences between the two types of training. Read through these to the group.

*Note*

This section is very important and should be carried out near the start of the training, as it has relevance to many of the exercises that will be carried out later.

Also give out the handout on Value Base of Disability Equality Training (Handout Ex. 2.2).

***Exercise 3: Attitudes and Awareness Exercise***

(Handout Ex. 3)

Split participants into pairs and ask them to state whether the statements are true or false. They need to explain why.

*Attitudes and Awareness Exercise – Answers*

Q1	The majority of disabled people are wheelchair users. – Less than 10% of disabled people use wheelchairs. Of this number, approximately 3% use wheelchairs full time.	False
Q2	You should never say, “I’ll be running along then,” or “see you later” to disabled people. – Disabled people use ordinary everyday language the same as you or me. Do not censure yourself or be over cautious, otherwise you will find conversations with disabled people stilted and unnatural.	False
Q3	70% of disabled people of working age are unemployed. – Many disabled people who would like to work cannot obtain jobs. Disabled people are regularly discriminated against in employment. Many employers think that they will take a lot of time off sick.	True
Q4	Exaggerating your lip movements can help someone who lip reads. – You should never exaggerate your lip movements, as this will distort your lip pattern, making it impossible for someone to understand what you are saying.	False
Q5	When meeting a visually impaired/blind person, always tell them who you are. – Do not assume that a blind person will know who you are automatically, or remember a voice from previous encounters.	True

Q6	All blind people like to wear dark glasses. – It is a common stereotype, popularised in films of the 1950s and by musicians like Stevie Wonder.	False
Q7	When talking to people who wear hearing aid you must always speak louder. – No. Hearing aids are designed to enable the wearer to hear more effectively.	False
Q8	When assisting a disabled person, you should always ask what is wrong with them. – Never ask intrusive or nosy questions. A person's impairment is his own business and not a subject for general discussion.	False
Q9	Wheelchair accessible toilets require a special key to open them. – Both apply. It is the policy of many companies to lock the wheelchair accessible toilets. Most supermarkets have wheelchair toilets together with other toilets and these are left open. A system called the RADAR key scheme, which is a universal key costing £3.00, will open locked toilet doors if the company subscribes to this scheme.	True and False
Q10	If a deaf person does not understand what you say the first time, you should keep on repeating the same thing until they do understand. – You may repeat yourself a second time. If they still do not understand, then you should rephrase the sentence using different words if needed.	False
Q11	People with mental illness are more likely to be dangerous and unpredictable. – They are no more likely to be dangerous than you or me. The media have sensationalised incidents to make the public generalise in all cases.	False

- 
- Q12 A blind person can hear better than a sighted person. False  
– A blind person may rely more on his other senses and learn how to use them better, but it does not necessarily mean that he can hear better.
- 
- Q13 People with Down's Syndrome cannot have a mental age higher than 10. False  
– Learning difficulties vary widely from person to person as it does with people without Down's Syndrome. It is wrong to make assumptions on the basis of someone's impairment.
- 
- Q14 All deaf people are very good at lip reading. False  
– Not all people with hearing problems are taught to lip read. Lip reading is not solely a reliable way to understand what is being said, as skilled lip readers can only understand about 50% of the spoken word and the rest is guess work. Sounds are also made in the back, middle and front of the throat and not on the lips.
- 
- Q15 If a person who has epilepsy is having a seizure, you should put something in his mouth. False  
– Do not interfere with someone having a seizure – trying to force something into his mouth could result in him breaking his teeth, choking on the object or you getting bitten.
-



**Exercise 4: Word Power Exercise**

(Handout Ex. 4.1 and Ex. 4.2)

*Aim*

To discuss the terminology used to describe disabled people and to highlight the words that disabled people prefer.

Split participants into pairs and ask them to go through the list of words and say if they feel the word portrays a positive or negative image or neither. Also ask them to explain the reason why they think this is.

*Word Power Exercise: Answer*

Look at the following words and ask yourself whether they suggest a positive or negative image.

*Wheelchair bound: Negative:* Disabled people prefer the term 'wheelchair user', they are not restricted to the chair as the word 'bound' suggests.

*The disabled: Negative:* This is labelling people under one group, e.g. the French, the Germans.

*Cripple: Negative:* A term used from the Victorian era, but today used in a detrimental way.

*Invalid: Negative:* Splitting the word up ('in valid'), makes the person of no worth.

*Integrated: Positive:* Integration means that everyone is included and has his needs met.

*Spastic: Negative:* A medical term but used nowadays in a detrimental way.

*Handicapped: Negative:* A Victorian term used to describe beggars with cap in hand begging for charitable handouts.

*People with learning difficulties: Positive:* People with learning difficulties have chosen this term. It describes their problem and the solution to that problem is to adjust in a different way to other people.

*Mental patient: Negative:* Associated with words like loony, crazy, mad and dangerous. People with mental health problems prefer to be called ‘survivors’ of the psychiatric system.

*Sufferer: Negative:* Disabled people do not normally suffer, unless it is at the hand of someone ignorant or offensive. They have an impairment that they live with.

*Special needs: Negative:* We all have the same needs – to eat, to drink, sleep, and move around. Disabled people are disadvantaged if their needs are not met. There is nothing ‘special’ about needing basic requirements in order to live from day to day.

*Spina bifida: Neither:* This is the name of a medical condition and is neither positive nor negative. However, if you add the word sufferer or victim, the effect is negative. Their condition is nothing more than the effect of their impairment.

*Independent: Positive:* Disabled people have been fighting for the right to live independently with whatever support they require and with that ability to make the same choices and have the same rights as every other member of society.

*Disabled person: Positive:* This is a term chosen by disabled people themselves. It is based on the Social Model of Disability, that their impairment plus a disabling factor makes them a disabled person.

On a prepared flip chart, have the Sum, described below, compiled by Susan Hemmings, which explains how it is the disabling factor that needs to be removed to allow inclusion. (Handout Ex. 4.2)

## SUM

Impairment	+	Disabling factor	=	Disability
Person with impairment	+	Experince of disenabling factor	=	Disabled person

***Exercise 5: Rights***

(Handout Ex. 5.1 and 5.2)

As the Social Model is based on a rights based approach, it is important that you carry out some work around rights. One way of doing this is by using the next exercise devised by Susan Hemmings.

*Aim*

To identify the links between human and civil rights, and entitlement, and how this underpins the Social Model of Disability.

You will need to provide a short link between disability awareness/disability equality and this section on rights, e.g. “Now that we have looked at what disability equality is, we are going to examine the rights of disabled and non-disabled people.”

You need to read all the background information so that you are able to explain rights and answer any questions. A useful tip is to keep a copy of sample answers at hand.

**OUR RIGHTS AS DISABLED PEOPLE***We have human rights*

This means we are fully human – not less than human because of our impairments or difference, not sub-human, or more like animals; and we matter, each of us, as much as any other human. In that regard, we are not special, no more so than anyone else.

Human rights afford us the *same* rights as everyone else.

Examples are: food, housing, freedom of speech, freedom from torture and injustice, freedom from discrimination.

*We have civil rights*

Civil rights have to do with being citizens – members of society. They

protect us as individuals and as social beings. As disabled people, we should have full civil rights.

Examples: The right to vote and take part in political debate and action, access to transport, choice of schools, access to social venues, all in ways that do not discriminate against us. Civil rights, like human rights, are based on the idea that we should be treated as non-disabled people because we are of equal value to society.

### *Entitlement*

As disabled people, we ask for *fair treatment*, which will sometimes mean that we need *different* treatment from non-disabled people. There are already many laws in place covering these rights.

One example in the United Kingdom is the 1990 Community Care Act which gives disabled people an entitlement to an assessment of their needs.

The reason we have these entitlements is to compensate to some extent for many years of unfair treatment, for example, because housing, equipment and employment have not been properly available to or designed for disabled people *in the same way that they have for non-disabled people*.

The way that society sees us as having 'special' (i.e. not normal) needs, means that our entitlements are seen as compensating us for a 'weakness' that is ours – usually our physical or mental impairment – rather than as changing society to include us as full members. It is seen as the strong (non-disabled people) 'caring for' the weak (disabled people).

Entitlement under the law does assist disabled people to obtain their civil and human rights, but in rather a back to front way!

### *Rights Exercise*

1. Give participants a copy of the Rights Handout (Handout Ex. 5.1).
2. On a prepared flip chart, give examples of human and civil rights (refer next page). Explain these briefly.

3. Split participants into three or four groups, depending on the size of the full group. Ask them to discuss each of the three statements A, B and C on Handout Ex. 5.1.
4. Give each group a prepared flip chart sheet (refer below). Have them choose one person to write their answers on this and to nominate one person to present feedback to the full group.

Prepared Flip Chart

<p><b>Human Rights</b>  <i>Examples:</i>                  Food                  Housing                  Freedom of speech                  Freedom from discrimination</p> <p><b>Civil Rights</b>  <i>Examples:</i>                  The right to vote                  Access to transport                  Choice of schools                  Access to social venues</p>
--

Prepared Flip Chart

<p><b>RIGHTS EXERCISE</b></p>
<p>Group ____</p> <p>What kind of rights?</p> <p>Do we have it in law?</p> <p>A</p> <p>B</p> <p>C</p>

*Allow 20 minutes for this exercise then return to the full group for the feedback session.*

For this you need to be aware of the rights of disabled people, have read all the background material and have read the sample answers on pages 26-27.

1. Keep participants in their groups. Ask each group in turn to provide feedback information from the flip charts.
2. Record their answers on your flip chart. Correct answers should be written in CAPITALS to distinguish them from others (see sample answer below).
3. Point out to groups *How we are the same* for A and B, and *How we are different* for C. Write these up on the flip chart.
4. Finally put up the flip chart (Handout Ex. 5.2), which shows the sum of disabled people's rights and explain how any subtraction from this sum equals an abuse of rights.

*At this point take a break for 15 minutes.*

#### *Rights Exercise: Sample Answers*

- A) Human rights, no difference, commonality, global, universal, moral, natural, instinctive, passionate, feeling, emotion, anger, outrage.
- B) In so far as others, COMMONALITY, legal, CIVIL RIGHTS, societal, CITIZEN, state, social.

Both 'A' and 'B' demonstrate how we are all the same.

- C) Legal, social services, discretionary, conditions, assessment, welfare, difference, ENTITLEMENT

'C' clearly shows how disabled people are different

#### *Rights Sum*

Human + Civil + Entitlement = Disabled people's rights

Any subtraction = Abuse of rights

***Exercise 6: Medical and Social Models of Disability***

(Handout Ex. 6.1 and Ex. 6.2)

*Aim*

To explain how an understanding of the Social Model of Disability is important in promoting change and to show the differences between the Social and Medical Models.

On prepared flip charts have 'Medical Model Says' and 'Social Model Says'. When reading through the points listed in 'Medical Model Says', explain how they focus on the individual disabled person.

During the explanation of 'Social Model Says' refer back to the sum of impairment plus disablating factor equals disability.

## Medical Model Says:

- ☹ You are the problem.
- ☹ Your disability needs curing.
- ☹ You cannot make decisions about your life.
- ☹ You need professionals to look after you.
- ☹ You can never be as equal as a non-disabled person.

## Social Model Says:

- ☺ 'Disability' is not an individual problem.
- ☺ We can't compete on equal terms because there are too many barriers.
- ☺ We need to recognise that 'society' (through the government and its agencies) has a duty to remove these barriers.
- ☺ Disabled people have the same RIGHT to full equality as do all other citizens.

***Exercise 7: Kim Exercise***

(Handout Ex. 7)

*Aim*

To demonstrate the differences between the Social Model and Medical Model.

Ask two people in the group to read out handout Ex. 7, one to read the faint print and the other to read the darker print. Explain that one is the professionals' attitude and the other is that of family and friends.

This can be followed by a brief discussion on the difference between the Medical and Social Models.



***Exercise 8: Medical and Social Model: Rewrite Exercise***

This is one of the exercises designed by the Greater Manchester Coalition of Disabled People to teach young disabled people about independent living.

The purpose of this exercise is to see if participants understand the difference between the Medical and Social Models. Before splitting the participants into smaller groups, read out the following sentence:

- John does not go to the local cinema because he is deaf and dumb and would not be able to understand the film.

Explain that this is written in the Medical Model and if it was rewritten in the Social Model it would change the focus from John being the problem to the cinema finding solutions, as follows:

- John does not go to the local cinema because the films are not subtitled.

Split the participants into groups and ask them to rewrite the following sentences for a full group feedback:

- a) Peter, who is 24 and suffers from muscular dystrophy, has to live with his parents because he needs a lot of looking after and his house is specially adapted.
- b) Vicky, who is 14 and is a spina bifida victim, is not able to travel to school with her best friend because she is wheelchair bound and has to use a special bus.
- c) Alice, who is 17 and blind, is not allowed to go to the football match with her mates because her parents think the crowds might injure her, and in any case she would not be able to follow the game.

***Exercise 9: Social Model***

(Handout Ex. 9.1, Ex. 9.2, Ex. 9.3)

After carrying out the feedback session with the group on the sentence rewrites, put up either a flip chart, acetate or power point showing Key Points on the Social Model of Disability (Handout Ex. 9.1). Read this out to the group.

Follow this up with the slide Why the Social Model Underpins Needs Led Assessment (Handout Ex. 9.2).

Finally put up Social Model of Disability Diagram and talk through each of the points (Handout Ex. 9.3).

After explaining these three slides, ask for comments. This will help you see if the participants have grasped the concept of the Social Model of Disability.

At this point, take a break but explain that you will be using some more exercises to explore the Social Model in more detail.

***Exercise 10: Kieron Exercise***

(Handout Ex. 10)

This exercise involves showing the video tape of Kieron Wild talking about himself and his experience of school. This short tape is part of a training pack devised by Susan Hemmings for the Open University.

As it is a short tape, it will be necessary to show it twice. Show the tape once, then explain to the participants that you are separating them into two groups and that one group will be asked to identify the disempowering factors (i.e. the barriers that the Social Model identifies) that affect Kieron.

The second group will be asked to focus on the Medical Model and to list the impairments he has.

Before showing the tape again, give out the prepared flip charts (refer to next page).

Also display the flip charts from the earlier session showing the differences between disability awareness and equality. Plus tell participants to refer to the Handouts on the Medical and Social Models of Disability (Handout Ex. 10).

For your own reference keep a copy of the sample answers on page 35 close at hand.

After the group has watched the tape for the second time, separate the participants into their respective groups and ask them to complete their tasks.

For the feedback session, keep both groups where they are but ask them to swap their completed flip charts. Then ask each group to discuss whether they agree or disagree with the points raised.

## Prepared Flip Chart

## Social Model

Kieron is affected by...  
(List disempowering factors)

Sample answers: Kieron is affected by...

exclusion, bad planning, discrimination, isolation, victimisation/bullying, prejudice/attitudes, built environment, lack of communication, system complacency, lack of equality, no voice/no outlet for expressing feelings, access problems, school disregarding its responsibilities as a service provider, no policy on inclusion, no support network e.g. no role models, peer group, disregard of his basic human rights, frustration

## Prepared Flip Chart

## Medical Model

Keiron is 'suffering' from...  
(List impairments)

Sample answers: Kieron is 'suffering' from...

cerebral palsy, handicap, high dependency, speech problems/special needs, depression, being unsociable, abnormality, vulnerability, limited dexterity, mobility impairment, communication difficulties, spastic gait, inferiority complex, being a loner, special needs case, sore feet, ultra sensitivity about impairments, being introverted and lacking in social skills, personality disorder, persecution complex, requiring special equipment, learning disability, being slow/stupid

***Exercise 11: Saturday Night Out***

For this exercise, tell the group you are going to show them a short video of two friends planning a night out. This is another video prepared by Susan Hemmings as part of an Open University course.

Ask the participants to watch the video and spot the barriers the two friends encounter.

After showing the video, ask a volunteer to record the answers on a flip chart pad. Keep the participants in a group and invite them to shout out the answers.

***Exercise 12: Independence***

(Handout Ex. 12)

*Aim*

To help people realise that independence equals choice and control.

Split the participants into three groups and give each group one of the prepared flipcharts (see below).

Show them the flip chart/acetate/power point (below, also Handout Ex. 12), and ask them to draw up a list of service delivery principles.

To help you prompt discussion of the issues, make sure you read the sample answers below.

Allow 20 minutes for the groups to carry out this task, then bring the full group back for a feedback session.

For the feedback session, extract the main service principles onto the flip chart (below). Note the sub-headings on this chart which help to demonstrate that Independence = Choice and Control.

The feedback session will also take twenty minutes.

**Prepared Flip Chart***Aim*

Participants to consider their own desire to be independent even when they are using other people to assist them/do the things they cannot do.

For them to analyse the factors they look for in service delivery in everyday contexts.

For them to devise a list of service delivery principles which give both disabled and non-disabled people choice and control.

Prepared Flip Chart

Service Delivery Principles: Group 1

Train journey

Restaurant

House decorator

Washing machine repair

Prepared Flip Chart

Service Delivery Principles: Group 2

Haircut

Car Service

Babysitter

Dentist

Prepared Flip Chart

Service Delivery Principles: Group 3

Heating repair

Travel agent

Hotel

Childminder

*Service Delivery Principles: Sample Answers*

*Train journey:* flexible, punctuality, comfort, staff attitudes, safety, refreshments, toilets, information, cost, location, redress, grievances, complaints.

*Restaurant:* quality food, health and safety, courteous staff, value for money, non-smoking, toilets, user friendly menus, complaints welcome, cost.

*House decorator:* quality of work, general honesty, value for money, health and safety, respect for property, redress agreement, timescale – contract.

*Washing machine repair:* general honesty, quality of work, cost.

*Haircut:* high standard, parking, cost, time, courteous service, choice, accountability/compensation.

*Car service:* proximity, reliability, competitive price, courtesy, speciality service, choice of service.

*Babysitter:* trustworthiness, punctuality, reliability, respect for child/family values, evidence of competence.

*Dentist:* user friendly, choice, reputation, competent, modern treatment, quality standards.

*Heating repair:* choice of service provider, reliability, reputation, availability, skill, honesty, local, cheap, competitive.

*Travel agent:* good up-to-date information, competitive prices, reliability, member of ABTA – for protection, good attitude.

*Hotel:* good attitude, value for money, comfortable, accessible, reputation, good service, choice.

*Childminder:* reputation, caring, safe environment, qualified/experienced, competitive, reliable.



## Service Delivery Principles: Facilitator's Chart

Car Service  
(Essential aid/equipment)

Rail Journey  
(Transport)

Decorator  
(Personal service in the home)

Haircut  
(Personal care)

***Exercise 13: Action for Change***

*Aim: What Can I and My Organisation Do Next?*

This session basically asks the question, “What can we do next?”

It is possible to discuss some practical issues as follows:

- Access issues
- Visual impairment
- Hearing impairment
- Disability etiquette
- Useful suggestions

*Outcome*

Implementation of changes to policies and procedures.  
Improved access to facilities – buildings and information.  
Attitudes, language and awareness.  
Taking responsibility.

## **Evaluation**

(Handout: DET Evaluation Form)

To finish off the training session, give participants the evaluation form (Handout: DET Evaluation Form) and ask them to complete it as honestly as possible, even if that means saying the training was ineffective. This is important because without this feedback, it is impossible to change the sections that do not work.

## **Session Planning**

(Templates: Day Plan & Session Plan)

All of the previous sessions have covered the main elements of DET plus the type of group work and feedback methods have been explored. However, as a facilitator, it is important that you can plan how to deliver a session.

You need to be able to set out the day plan for your course clearly showing the aims, timetable and methods you will be using.

A blank template is included (Template: Day Plan).

For this next part, you are asked to choose one of the following topics and prepare a ten-minute session:

1. Defining who is disabled
2. The main access barriers for disabled people
3. The Medical Model
4. The Social Model
5. Why language must change
6. Attitudes

Again, a blank template is shown at ‘Template: Session Plan’, but it is important that you define your role and that of the participants.

## **Section 2: Participants' Handouts**

### *Handout Aims and Objectives*

#### *Aims*

To enable staff to develop an understanding of disability that is based on the Social Model of Disability and to identify areas within their organisation/venue that could be changed to promote the participation of disabled people.

#### *Objectives*

- To identify language which is offensive to disabled people and to use more acceptable terms.
- To begin to question and challenge attitudes and levels of awareness regarding disability.
- To critically examine the Medical Model of Disability and to introduce the Social Model of Disability.
- To identify areas for change and to develop an action plan for implementing change.

***Handout Ex. 1****Famous People Exercise*

---

Julius Caesar	Roman emperor
John Cleese	Comic actor – Fawlty Towers
Bill Clinton	USA president
Tom Cruise	Actor
Daniel Day Lewis	Actor
Albert Einstein	Physicist/mathematician
Stephen Hawking	Professor of theoretical physics
Steve Redgrave	Olympic gold medallist
Christopher Reeve	Actor
Franklin Delano Roosevelt	President of the USA
Vincent Van Gogh	Artist/painter
Stevie Wonder	Singer/songwriter

---

***Handout Ex. 2.1***

DET vs DAT

DISABILITY AWARENESS TRAINING ASKS

What is your *problem* (disability)?

How can we *help*?

What are your *special* needs?

DISABILITY EQUALITY TRAINING ASKS

What are my *responsibilities* as an employer or service provider?

How can I ensure a *fair and inclusive* employment practice/service delivery practice?

Direct links to other areas of equality training, e.g. racism, sexism.

***Handout Ex. 2.2***

VALUE BASE OF DET

- Establish disability as a rights issue.
- Recognition of diversity.
- Equality of opportunity.
- The Social Model of Disability as defined by disabled people *collectively*.
- Using the Social Model to inform changing practice.
- Anti-oppressive behaviour (challenging and interrupting oppression at all levels).
- Empowerment of disabled people.

**Handout Ex. 3**

## ATTITUDES AND AWARENESS

Q1	The majority of disabled people are wheelchair users.	True/False
Q2	You should never say “I’ll be running along then,” or “see you later” to disabled people.	True/False
Q3	70% of disabled people of working age are unemployed.	True/False
Q4	Exaggerating your lip movements can help someone who lip reads.	True/False
Q5	When meeting a visually impaired/blind person always tell them who you are.	True/False
Q6	All blind people like to wear dark glasses.	True/False
Q7	When talking to people who wear hearing aids, you must always speak louder.	True/False
Q8	When assisting a disabled person, you should always ask what is wrong with them.	True/False
Q9	Wheelchair accessible toilets require a special key to open them.	True/False
Q10	If a deaf person does not understand what you say the first time, you should keep on repeating the same thing until he does understand.	True/False
Q11	People with mental illness are more likely to be dangerous and unpredictable.	True/False
Q12	A blind person can hear better than a sighted person.	True/False
Q13	People with Down’s Syndrome cannot have a mental age higher than 10.	True/False
Q14	All deaf people are very good at lip reading.	True/False
Q15	If a person who has epilepsy is having a seizure you should put something in his mouth.	True/False



**Handout Ex. 4.1**

WORD POWER

Look at the following words and ask yourself whether they suggest a positive or negative image.

Wheelchair bound	Positive / Negative / Neither
The disabled	Positive / Negative / Neither
Cripple	Positive / Negative / Neither
Invalid	Positive / Negative / Neither
Integrated	Positive / Negative / Neither
Spastic	Positive / Negative / Neither
Handicapped	Positive / Negative / Neither
People with learning difficulties	Positive / Negative / Neither
Mental patient	Positive / Negative / Neither
Sufferer	Positive / Negative / Neither
Special needs	Positive / Negative / Neither
Spina bifida	Positive / Negative / Neither
Independent	Positive / Negative / Neither
Disabled person	Positive / Negative / Neither

**Handout Ex. 4.2**

SUM

Impairment	+	Disabling factor	=	Disability
Person with impairment	+	Experince of disenabling factor	=	Disabled person

***Handout Ex. 5.1***

RIGHTS EXERCISE

- A. Disabled people have the RIGHT to be parents.
- B. Disabled parents have the RIGHT to sit with their children in the cinema.
- C. Disabled parents have the RIGHT to childcare support in the home.

Most people would agree with these statements, even if they are not sure whether disabled people have these rights in law.

A, B and C are different kinds of rights.

Can you say what the differences are?

Do they exist in law or in any other form?

***Handout Ex. 5.2***

RIGHTS SUM

Human + Civil + Entitlement = Disabled people's rights

Any subtraction = Abuse of rights

***Handout Ex. 6***

MEDICAL MODEL SAYS

- ☹ You are the problem.
- ☹ Your disability needs curing.
- ☹ You cannot make decisions about your life.
- ☹ You need professionals to look after you.
- ☹ You can never be as equal as a non-disabled person.

SOCIAL MODEL SAYS

- ☺ 'Disability' is not an individual problem.
- ☺ We can't compete on equal terms because there are too many barriers.
- ☺ We need to recognise that 'society' (through the government and its agencies) has a duty to remove these barriers.
- ☺ Disabled people have the same RIGHT to full equality as do all other citizens.

**Handout Ex. 7***Kim Exercise*

- ☹ He shows a moderate developmental delay at two years eight months, with skills falling a little further behind owing to a developmental plateau.
- ☺ *Kim's a toddler with a great laugh and a lot of energy.*
- ☹ He is showing a marked developmental regression.
- ☺ *Kim tries so hard all the time. He never gives up.*
- ☹ He has severe intractable epilepsy and will need to be placed in a special school with a special care unit.
- ☺ *Kim is an ordinary lad who needs to do ordinary things with all other children his own age.*
- ☹ He is very passive.
- ☺ *Kim is so easy to be with.*
- ☹ He has autistic tendencies.
- ☺ *Kim communicates so beautifully.*
- ☹ He is often uncooperative.
- ☺ *Kim is easy going.*
- ☹ He can't behave like that. He simply has to stop!
- ☺ *I love it when he gets excited. His enthusiasm is so infectious.*
- ☹ He needs respite care.
- ☺ *Kim needs babysitters and friends.*
- ☹ He has frequent seizures. These constitute a major problem.
- ☺ *Kim has frequent seizures. They are part of him.*
- ☹ He has complex communication difficulties.
- ☺ *Being with Kim allows me to be myself – to get away from all the peer pressures and pressures of the world.*

From: *Let our Children Be*, compiled by Pippa Murray and Jill Penman. (Parents with Attitude c/o 44 Cowlishaw Road, Sheffield, S11 8XF).

***Handout Ex. 9.1***

*Key Points on the Social Model of Disability*

1. It was developed by disabled people to describe and take action against discrimination.
2. It was developed to frame the ‘problem’ of disability in social terms rather than viewing the disabled person as the problem.
3. It enables us to identify specific areas for change and, in particular, to identify negative attitudes, communication barriers and physical access as major areas for improvement.
4. It enables all disabled people to join together to campaign for better attitudes, improved communication and access, no matter what their impairment.
5. It enables disabled people to express their situation in terms of human rights and as an issue of equality.
6. It takes the focus of what disabled people cannot do and puts it on what we would all do, in alliance, to bring about this equality.

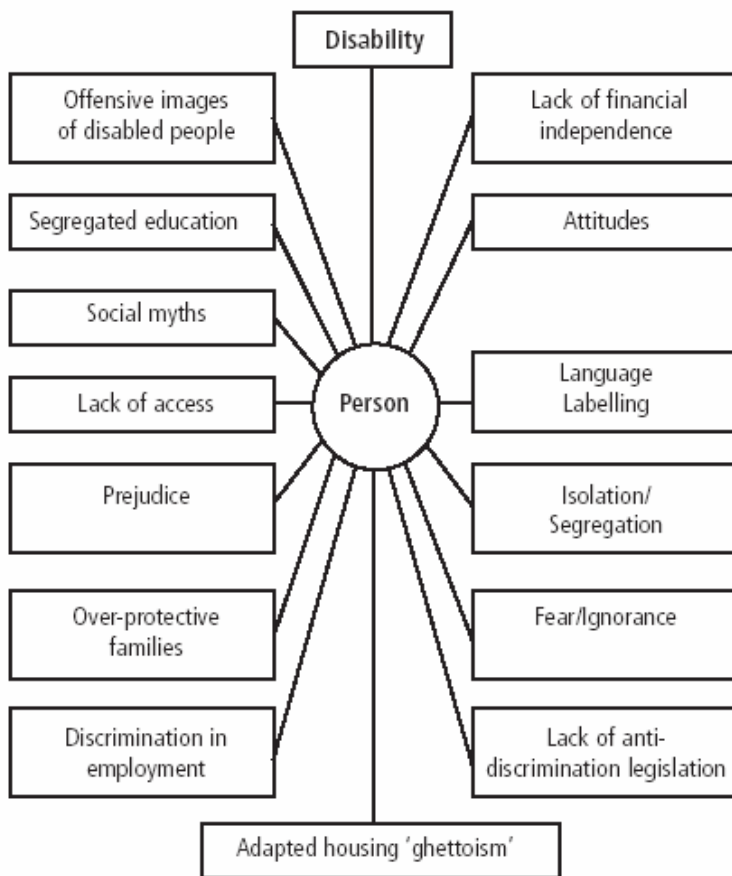
***Handout Ex. 9.2***

*Why the Social Model Underpins Needs Led Assessment*

1. It recognises equality and rights as the basis for service provision.
2. It values participation and self-diagnosis of need.
3. It permits the disabled person to take risks.
4. It changes the relationship of the disabled person from one of supplicant/dependent to partnership and interdependence.
5. It promotes social justice – not social welfare.

*Handout Ex. 9.3*

*Social Model Diagram*



This diagram illustrates the disabling forces at work where the Social Model is applied.

Source: SEATID Edinburgh taken from: "Altogether Better" Training Pack.

***Handout Ex. 10****Medical and Social Models of Disability**Medical Model*

The society we live in considers disability to be a tragedy for the individual and a burden for the family and society. This is based on the Medical Model of Disability. This model focuses on the lack of physical or mental functioning and uses a clinical way of describing an individual's disability. There are developmental norms, and functioning norms against which the person is judged. This model leads to a dehumanising view, where only the nature and severity of the impairment is important, together with the extent to which the difference can be put right or mitigated. It casts the individual as victim.

Disabled people have rejected this model. They say it has led to their low self-esteem, undeveloped life skills, poor education and consequent high unemployment levels. Above all, they have recognised that the Medical Model requires the breaking of natural relationships with their families, communities and society as a whole.

*Social Model*

Disabled people have arrived at a different 'model' to help understand the situation. They are challenging everyone to give up the idea that disability is a medical problem requiring 'treatment', but to understand instead that disability is a problem of exclusion from ordinary life.

This is what is known as the Social Model of Disability, requiring a change in society's values and practices in order to remove the barriers to participation which truly disable people. It is clear that this is possible and is starting to happen, e.g. changing steps into ramps, information in braille, valuing different learning styles. The understanding of the Social Model of Disability by non-disabled people builds a community of allies that will speed up the process towards this attitudinal change. This in turn will have a positive impact on creating a barrier free society that will gain the full benefit of the talents and contributions of all its citizens, i.e. disabled young people will take their rightful place in education, the workforce and all aspects of community life.



***Handout Ex. 12***

INDEPENDENCE

*Aim*

Participants to consider their own desire to be independent even when they are using other people to assist them/do the things they cannot do.

For them to analyse the factors they look for in service delivery in everyday contexts.

For them to devise a list of service delivery principles which give both disabled and non-disabled people choice and control.

Handout

***DET EVALUATION FORM***

- In your own words, what was this training session aiming to achieve?
  
- What did you think about the content of the training? (Was it relevant, interesting and what you expected?)
  
- In what ways, if any, can you put the skills and knowledge gained in this training into practice?
  
- Were there any issues raised which you feel need further attention?
  
- Is there anything else you would like to mention to assist us with the improvement of our training?

Template

***DAY PLAN***

(CLIENT)

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(AIMS)

- - 
  - 
  -
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PROGRAMME: DAY COURSE FOR 12 PARTICIPANTS

	SESSION	METHODS
9.30		
12.45	LUNCH	
4.30		

Template

***SESSION PLAN***

NAME OF SESSION:		EQUIPMENT:	
PREVIOUS SESSION WAS:		MAIN METHODS:	
MAIN AIM OF SESSION:			
TIME	SESSION PHASES – METHODS, CONTENT, ROLES		
	You	Them	
(1st) 10 mins			
(2nd) 10 mins			
Etc.			

## Handout

### *Some Useful Suggestions*

Most people want to treat disabled employees, job applicants and customers the same way as everyone else but are not always sure how to go about it.

These suggestions are not part of the new law but they may be useful when you meet disabled people.

- Disabled people are individuals just like everybody else. Do not make assumptions about their abilities or needs. Do not forget there are hidden disabilities such as epilepsy and mental illness.
- If you are not sure how something might affect a disabled person, ask him for advice.

### *Communication*

- If a disabled person is with someone, talk to the disabled person directly, not to the person who is with him. This also applies to a deaf person accompanied by a sign language interpreter.
- When talking to a deaf person, find out – if necessary in writing – whether he lip reads. If he does, make sure your face is in the light, look directly at the person, speak clearly and naturally, remembering to keep your hands away from your face.
- When you first meet a blind person, introduce yourself. When you are going to move away, tell him. Do not leave him talking to an empty space.
- When you are talking to someone with a speech impairment, concentrate on what is being said, be patient and do not try to guess what he wants to say. If you do not understand, do not pretend you do.

- If someone has difficulty understanding you – perhaps because he has a learning disability – be patient and be prepared to explain something more than once. Concentrate on using simple language.
- When talking to a wheelchair user, try to ensure that your eyes are at the same level, perhaps by sitting down. Do not lean on the wheelchair – it is part of the user’s personal space.
- Avoid asking personal questions about a person’s disability such as, “*Were you born like that?*” But an employer could ask, “Does your disability affect your ability to do this job?”
- If someone looks ‘different’, avoid staring. Concentrate on what he is saying not on the way he looks.
- If you are talking to an adult, treat him like an adult.

### *Assistance*

- If someone looks as if he needs assistance, offer it, but wait for him to accept before you help.
- When guiding a blind person do not push or pull him. Ask if he would like to take hold of your arm. If there are steps, tell him whether the steps go up or down.
- Remember that guide dogs for blind people, hearing dogs for deaf people and other assistance dogs are working dogs, not pets. They should not be fed, patted or distracted when they are working.
- Above all, put yourself in the disabled person’s place. Most of the above points are just good manners.

### *Language*

Some of the words and phrases we use offend disabled people because they suggest that the disabled person is dependent or helpless. Some words such

as ‘cripple’ or ‘retarded’ have become terms of abuse or are used to make fun of disabled people. Below are some common words to *avoid*, together with some suggested alternatives.

<i>Do not say</i>	<i>Use</i>
the disabled	disabled people / people with disabilities
suffering from / crippled by / afflicted by / a victim of	a person who has / a person with
deaf and dumb	deaf without speech
an epileptic	a person with epilepsy
spastic	a person with cerebral palsy
mentally handicapped / subnormal	a person with a learning disability
confined to a wheelchair / wheelchair bound	a wheelchair user

Issued on behalf of the Minister for Disabled People.  
Prepared in conjunction with the National Disability Council and  
RADAR.

## Postscript

Society throughout the world is changing and people are becoming more aware of their rights as citizens. Disabled people in the United Kingdom have adopted the Social Model of Disability as a means to further their inclusion into society. I have witnessed how attitudes of non-disabled people in Northern Ireland and the rest of the United Kingdom have changed after attending Disability Equality Training. This change in attitude has resulted in changes in policies, practices and procedures in the workplace and among providers of goods and services.

The new United Nations Convention on the Rights of Disabled People has incorporated the Social Model of Disability into its charter and this will, hopefully, have a significant impact throughout the world towards finally including disabled people as full citizens.

It was an honour and a privilege to be involved in bringing the concept of the Social Model of Disability and Disability Equality Training to those participants on the course. I was heartened to see the commitment and enthusiasm each individual brought and the willingness to challenge his own perceptions about disability. In addition, for many, Disability Equality Training was in stark contrast to the culture and environment in which they lived and worked in. So, I am aware that moving from disability equality theory into practice is the start of a long journey on the road towards achieving this cultural change. But, from witnessing the commitment of the participants, I have no doubt that they have the strength to continue this journey.



My gratitude to the Arts Council of Northern Ireland, colleagues, friends and allies for their cooperation and contribution. I would finally wish to thank JICA and Dr Kenji Kuno for their belief in this project and for giving me the chance to pass on the baton to those who campaign for change.

*Kevin McLaughlin*