

DISABILITY EQUALITY TRAINING

Action for Change



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LIZ CARR | PAUL DARKE | KENJI KUNO

The true nature of "disability" is neither the mere functional limitations of individuals, nor the difficulty of performance which results directly from such limitations. "Disability" is oppression, discrimination, social exclusion and restriction of participation which is socially constructed and imposed upon people who are regarded as different in terms of body functions and structures. Therefore, disabled people are neither less-able nor in-able, but are dis-abled by the society which takes little or no account of people who have different functions and structures.

This perspective on "disability" is called the Social Model of Disability, which forms the conceptual foundation of Disability Equality Training (DET). DET is a disability education concept which aims to promote understanding of disability from the Social Model perspective and facilitate proactive actions to break disabling barriers in our society. DET uses facilitated and participatory learning approaches in its training methods.

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Preface

This is the fifth book of a series of Disability Equality Training (DET) manuals for DET Trainers. This is the reedited version of the first manual of the series, "Training Them and Us: A Guide to Social Equality for Society" by updating the contents and adding a new chapter on experiences in DET in the Majority World or the Global South. This series of manuals is published as a part of the Project on Disability, implemented by the Japan International Cooperation Agency (JICA) and the Department of Social Welfare, Ministry of Women, Family and Community Development, Malaysia. This project, the Project to Support Participation of Persons with Disabilities, is implemented to promote the participation and inclusion of disabled people and mainstream 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. The DET Forum was also formed as a network of DET trainers under this project in 2005. Over

100 trainers were trained by this and other JICA projects in the past seven years. They are actively engaging in DET in their countries, namely: Malaysia, Thailand, Singapore, Indonesia, Nepal, Bangladesh, Pakistan, Kyrgyzstan, Maldives, Afghanistan, Philippines, Costa Rica, Papua New Guinea, India and Uzbekistan.

I truly hope that this book will provide useful information and ideas on DET. I also welcome comments and suggestions. Please visit DET Forum's website at www.detforum.com and provide your comments.

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 Social Participation, Inclusion in the Community, and Empowerment of all disabled people. So, let's "SPICE up" our work on disability together!

Kenji Kuno
Kuala Lumpur
March 2012

Part 1

The Principles and Practice of Disability Equality Training (DET)

LIZ CARR & PAUL DARKE

This section gives a basic introduction into DET, what it is, and answers some frequently asked questions (FAQs) about it. This section also explains basic principles of DET and examines how we transform a knowledge of disability issues into a DET course by looking at content, example programmes and exercises.

■ 1. Introduction to DET

Disability is not a 'minority' issue; government estimates state that there are approximately 8.6 million disabled people in the UK – a 'minority' of at least 14% of the population.

The Social Model of Disability, the basis for disability equality training, needs to be within the reach of as many people as possible, disabled and non-disabled alike and the internet is an ideal way for people wishing to increase their knowledge to find the information and training they require.

In light of the Disability Discrimination Act 1995 and the Human Rights Act 2000, many public and private sector bodies have realised that their work practices and policies fall far short of fulfilling the needs, rights and aspirations of disabled people who are their clients, customers and co-workers and that, in order to change this situation, they need to turn to disabled people to deliver quality Disability Equality training.

With this growing demand for DET run by disabled people, it is hoped that this book will allow many more disabled people to learn about the Social Model of Disability, become DET trainers and to start working with organisations to help them understand the meaning of disability, identify changes in work practice, and plan strategies to implement change.

Who is this book for:

- those of you with little or no knowledge of DET
- those of you who would like a re-cap on their DET knowledge
- those disabled people who are interested in becoming DET trainers
- It may be that you have recently been on a DET course or perhaps you've just heard the term and would like to find out more?
- Maybe you are a Disability Equality Trainer or perhaps you're a disabled person who would like to become more involved?
- Whoever you are, disabled or non-disabled, whatever knowledge you have of disability issues and experience of DET

■ 2. What is DET?

Disability Equality Training is a participatory process where people are introduced to the real issues and discrimination facing all disabled people with a view to them changing their behaviour, policies and practices.

As with other equality training, Disability Equality Training courses are designed and delivered by the people who have directly experienced discrimination i.e. qualified disabled trainers who experience disability as a form of social oppression and therefore truly understand the reality of living in a disabling society.

DET is not some newfangled trendy idea but has been in existence in some form or other since the early to mid-Eighties and has its history rooted firmly in the Disabled People's Movement. Based on the direct, collective experiences of disabled people, recognising that the problem is one of institutionalised discrimination, DET puts emphasis on "action": i.e., making changes within working environments and society, by looking at the barriers within the workplace and encouraging participants to form a plan of action to remove the barriers.

DET is about:

- The Social Model of Disability;
- Disabled people leading the training;
- Examining the barriers faced by disabled people in society;
- Questioning stereotypes, myths and misconceptions about disabled people;
- A commitment to change.

DET is not about:

- Making non-disabled people feel guilty;
- Non-disabled professionals discussing disabled people's lives;
- Disabled people recounting their life story;
- Simulating physical, sensory or mental impairments;
- Giving information about specific medical conditions.

■ 3. Why Do We Need DET?

For many years trainers, often non-disabled trainers, have been delivering Disability Awareness courses often from an individual perspective as a way of demonstrating the different needs of people with a particular impairment. Heightening awareness usually takes the form of trying to change people's attitude towards disabled people.

One way of achieving this is through 'simulation' exercises where, for example, participants are blindfolded so they know what it feels like to be blind or use a wheelchair for a few minutes to know what it must be like for someone who is a wheelchair user. This individualises disability by focusing on what it's like not to see or walk and trivialises the discrimination and barriers which disabled people experience.

For disabled people to have any chance of participating in their own right within their community, we have to change more than attitudes. We have to change the environment, systems and institutions within which we live. This can only be achieved by understanding the issues which effect our lives from a Social Model perspective, addressing the barriers that exist and changing policies and practices which exclude us.

A key principle of DET is, therefore, having disabled trainers as experts and role models working to facilitate the change in perspective and behaviour of course participants.

DET moves beyond winning hearts and minds and asking non-disabled people to see the person but instead demands that organisations recognise disability as an equality issue, making parallels with other marginalised groups within society.

■ 4. DET vs. Disability Awareness Training

Although some people who run courses use these terms interchangeably, there is a big difference between Disability Equality Training (DET) and Disability Awareness Training (DAT):

DET	DAT
disabled trainers	non-disabled trainers
focus on discrimination	focus on impairments
disabled people as experts	professionals as experts
direct experience	simulation
rights & equality	'special needs' & etiquette
changes in behaviour/action	changes in attitudes
based on SM of Disability	not based on the SM
accountable to DPM	not accountable to DPM

SM = Social Model of Disability

DPM = Disabled People's Movement

■ 5. Who Delivers DET?

Disabled people with a Social Model perspective to disability.

It is not enough to be a disabled person and it is not enough to understand the Social Model of Disability. However, it is a core principle of DET that all courses are run by disabled people with a solid understanding of the Social Model of Disability and the Disabled People's Movement.

Disabled people with some level of group work/training skills.

Training and group work skills are also important but it is worth noting that the traditional way of training may be inaccessible to some disabled people. If we take a Social Model approach to training, we can see the barriers to training as problems which we can solve through creative and accessible solutions: e.g., short courses, regular breaks, adapted equipment, using images, words and/or drama to facilitate learning.

The barriers disabled people face in education, training and employment need to be recognised so they do not prevent a person from having the opportunity to become a trainer.

Disability Equality Trainers may be members of organisations of disabled people, of DET organisations/groups/forums or freelancers/individuals.

■ 6. Who Attends DET Training?

Anyone – disabled or non-disabled – can attend a disability equality event. Public, private and voluntary sector bodies may commission training from an organisation or individual for a cross group of employees or perhaps for a specific group.

There are, unfortunately, few training opportunities for the general public who do not have access to courses through work or other involvements.

DET is mostly associated with the training of non-disabled people but it is essential that there are DET or Personal Development Courses (PDCs) for disabled people only. Such courses will be founded on exploring and recognising the commonality of direct experiences and leading participants to examine the issues of disability equality in a safe and supportive disabled-persons-only environment.

Personal development courses are usually run by organisations run and controlled by disabled people.

■ 7. Aims & Objectives of DET

Whilst individual styles and methods may differ, DET training should have core aims which are consistent with the Disabled People's Movement. I.e., DET is designed and delivered by disabled people to enable participants to understand 'disability' from a Social Model perspective and to commit to removing disabling barriers.

The core aims of DET must be non-negotiable but beyond that, it is good practice that courses are always tailor-made to suit the objectives and needs of the people buying in or requesting the training. An example set of aims and objectives from the London Boroughs Disability Resource Team guide to disability equality training:

Aim

A DET course will enable participants to identify and address discriminatory forms of practice towards disabled people by encouraging an understanding of disability issues and their implications. DET aims to initiate action towards creating a society in which disabled people have the right, opportunity and choice of realising their potential as fully functioning citizens.

Objectives

The Aims will be met through the following objectives:

- to reach a social as opposed to an individual/ Medical Model of Disability;
- to challenge some of the common myths and assumptions surrounding disability and disabled people;
- to demonstrate the practical application of equal opportunities policies for disabled people within the immediate area of work of course participants;
- to recognise that disabled people may experience multiple oppression and that specific strategies need to be developed to challenge this form of discrimination;

- to formulate an action plan of constructive changes which participants can make to their work situations and personal lives and that will contribute to the gathering momentum for change in the social economic and political position of disabled people;
- to equip participants with a practical understanding of the models of disability, enabling them to recognise discriminatory language and images which perpetuate the oppression of disabled people.

■ 8. Course Length

A minimum of 2 days is recommended to run an effective DET. A 1/2 day follow up 3-6 months later is suggested good practice, allowing time to re-cap on core issues and for feedback of action plan changes and commitments. These, of course, are ideals and in the current training climate of best value and damage limitation, organisations are keen on 'disability training' but are less keen to release their staff for more than a few hours.

Requests for 2 hour sessions are more likely than for two-day training events and follow-up sessions are a real luxury; it is up to the training organisation or individual trainer to decide on their minimum time requirements for delivering effective DET.

Arguments 'for' delivering DET regardless of the time period include:

- 'something is better than nothing';
- 'lets get our foot/wheels in the door and see what it leads to';

- 'if we don't do it, someone else will anyway';
- '2 hours or 2 days, if they're going to get it they'll get it';

Arguments 'against' training DET in less than the ideal include:

- 'they just want to do a couple of hours and tick the disability box';
- 'it's nothing more than tokenism';
- 'there's no real time/intention for change';
- 'a little bit of knowledge is a dangerous thing'.

■ 9. Process of the Programme

DET courses are designed to allow incremental learning throughout the session and it is this building block approach which allows participants to build up their understanding of these new issues by using their existing knowledge, new information and a structured programme.

The first part of a session, whatever length the course, is the time for participants to grasp the Social Model philosophy and ideally a minimum of half a day should be devoted to re-defining disability: it takes time to 'un-programme' people after a lifetime of living within a Medical Model world.

Re-defining disability is an ongoing process throughout the course. Examples should be given as to how disability is created and maintained in society by barriers. Images, language and media portrayals could be examined with 'positive' alternatives presented. Every negative

demonstration of discrimination should be countered by a positive real life solution.

At end of the first day or the end of the session available, participants should be able to apply some of the knowledge gained to a short exercise/action plan relating to themselves and their jobs. An experience common to all forms of equalities training is that at this point in an event, it is quite likely that trainees may feel overwhelmed by the enormity of the issues. This is to be expected when exposing societal oppression and the part an individual participant would have unconsciously played in it. Ideally, therefore, a consecutive second day could allow you to deal sensitively and productively with this new knowledge rather than leaving participants high and dry.

A second day would allow participants to look at their area of work in detail, providing them with tools to identify the areas of discrimination and to challenge them. Re-affirming the Social Model, situating disability within a rights-based framework and this includes rights and drawing parallels and links with other oppressed groups would be other suitable topics for a second day of training. Relevant rights, legislation and organisational policies would have a significant slot and provide a basis for action planning for change so that by the end of the course all participants are equipped with the knowledge of not only what they must do AND why they should do it.

■ 10. Typical Content

There is no standardisation in the content of Disability Equality Training courses. However, all DET will include an exploration of:

- the Social and Medical models of disability;
- disabling barriers;
- disability as an equality issue;
- language and images of disability;
- the disabled people's movement;
- the potential for change through action planning.

The following more detailed headings relate to the typical content of a DET session:

Ground Rules

It is good practice in all training events to apply a set of ground rules which participants agree to observe during the course to allow for a safe, inclusive and productive learning environment which allows everyone equality of participation.

Warm-Up

A simple but important part of any session where everyone has an opportunity to contribute and be heard or be involved in the activity.

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 accessible information,

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 re-defined disability using their direct experiences as the basis for the Social Model of Disability. One of the first and ongoing tasks 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 Peoples' 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 this holds for them – it's 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 a rights issue – the Social Model acknowledges that it is not the individual's 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 oppression 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 disabled people are viewed, and portrayed in the media, in particular charity representation of disability balanced by a more accurate picture of disability as illustrated in disability arts and 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.

Evaluation

The training, the trainer, the venue, the feelings of the participants, the relevance, the learning, the good and the bad of the training are all usual topics to evaluate following a session.

Depending on the requirements of the organisation requesting the training, courses may be more focused on specific areas of relevance. Additional topics might include:

- the Disability Discrimination Act 1995 (DDA);
- independent living and 7 needs;
- user-involvement and consultation;
- direct payments and personal assistance;
- inclusive education;
- employment issues – recruitment, selection and retention.

■ 11. Courses for Disabled People

Background

It's likely that disabled people will be participants on DET courses; sometimes obviously but more often not as many impairments are hidden and non-evident. This is very different, however, to delivering courses which are only for disabled people. As with other discriminated against groups in society, disabled people have recognised the importance of joining together in disabled-people-only space, to learn and discuss and re-define disability from a point of direct experience.

This 'politicisation' of disabled people around the core understanding of the Social Model of Disability is rooted in our history and in the history of the development of the disabled people's movement when informal networks of disabled people gathered together to discuss their experiences of disability and the seeds of the Social Model were sewn. This moving from an individual experience to a

collective identity as disabled persons often comes from such informal contact with other disabled people but some groups may run courses which are entitled things like 'personal development', 'empowerment', 'disability issues', 'the personal to the political' training.

Content

The courses are not about how 'bad' our impairments are, or whether we're better/worse than anyone else, they are instead about sharing our experiences as Disabled People – both positive and negative and in doing so recognising the similarities and shared barriers and discrimination we experience regardless of our different impairments. Through a programme which moves us from our personal experiences to a shared understanding of the Social Model of Disability, these courses provide a liberatory framework as we can remove the blame imposed by the Medical Model and place the responsibility squarely on society where it belongs.

Typical issues covered include: barriers and solutions, the Social/Medical Model of Disability, our history, media, imagery, language, attitudes and assumptions, fighting for our rights, the law, independence vs. care, independent living, the Disabled People's Movement and other civil rights issues.

Whilst the content of courses for disabled people and DET are similar, there are inherent differences due to the fact that the content is directly about disabled peoples lives. For instance, what might be an interesting example of discrimination for non-disabled people could be a painful

real-life experience for disabled people – thus the responses and the consequences will be completely different.

Example Aims, Objectives and Programme

'Understanding Disability' – a 2-day course for Disabled People

The Aims of the course are:

- To provide disabled people with a practical and accessible understanding of the Social Model of Disability through sharing direct experiences, exploring common barriers and tutor input.
- To equip disabled people with the information, skills and confidence to re-evaluate their life experiences and opportunities from a Social Model understanding of disability.

Objectives of the course are:

- To share common experiences
- To discuss and identify the barriers disabled people experience
- To gain an understanding of the Social Model of Disability
- To recognise and explore the rights of disabled people
- To explore positive and negative words for and images of disabled people
- To learn about the Disabled Peoples Movement and its history
- To gain an understanding of independent living

- To recognise individual skills, strengths and resources
- To develop short-, medium- and long-term goals
- To identify future opportunities, training and information needs

The only qualification for this course is that participants define themselves as disabled people as this course is only open to disabled people.

Day 1

Time	Contents
09.30	Introductions & Warm-up
10.00	Hopes & Concerns Big group – one hope and one concern – flipchart
10.15	Ground Rules
10.45	Disability Is ... One word or short sentence that sums up what disability means to you. Flipchart. Is this list unique to only this group? This is our starting point – we’re going to look beyond our immediate situation & look at our history and connect with other disabled people
11.15	Coffee
11.30	Barriers Exercise 3 groups: Attitudes Environment (physical/information) Systems/services (education system)
12.15	Video – A different approach
12.30	Social and Medical Model flipchart presentation
01.00	Lunch
02.00	Images of Ourselves Where do we see DP in the media? How are disabled people portrayed by non-disabled people? Going to take a closer look at charity adverts/campaigns Charity & Negative Images – Aliens have landed

on the planet Earth and the only information they have are charity adverts/campaigns/posters. 2/3 groups look at charity images and discuss:

- What impression of disabled people will the aliens get from these?
- What are disabled people like? Who are disabled people?

Feedback – Society’s views of disabled people are shaped by these images and affect our self-esteem.
Celebratory Images – In same groups, list feelings/re-sponses to examples of self-representation
Feedback – why are the feelings and responses so different?

03.30 Coffee

03.45 **Introduction to the Movement & History of Disability –**
Video & Discussion

04.30 Close

Day 2

Time	Contents
------	----------

10.00	Welcome and Re-cap
--------------	---------------------------

10.15	The Charity Issue
--------------	--------------------------

Think of a disability charity (flipchart): What do they have in common?

Impairment specific ... Run by non-disabled people for disabled people ...

History of charity – set up to maintain institutions – separate us from each other – competing for funds.

Are there any organisations for all disabled people?

Anyone heard of the BCDP* ...

Are the major disability charities, none of which are run and controlled by disabled people, in any way accountable to them? Look at other examples of white

people claiming to represent black people's interests;
men speaking for women ...

10.45 Language - Does it Matter?

11.15 Coffee

11.45 Independent Living:

What does this mean for disabled people?

Whole group discussion

What do we need to live independently?

Groups & feedback as 7 needs.

12.30 Lunch

01.30 Dare to be You!

Individual opportunity to explore skills and qualities

02.15 Personal Action Plan

What do you want to achieve in life? What are the barriers/solutions?

03.00 Coffee

03.15 Discrimination in Our Lives

3 groups each discuss a time in their lives when they felt discriminated against:

- Medical Profession
- Leisure
- Employment
- Service provision

Will not be shared with large group. Take one example and discuss solutions if tackled collectively - group solutions feedback to whole group.

Feedback - There is a need for a collective response to discrimination - too hard to fight discrimination on our own. We can change things by getting together ... Disability Movement ...

04.15 What next: Discussion and information Exchange

04.30 Closing Thoughts & Evaluation

05.00 Goodbye

*BCODP: The British Council of Disabled People

■ 12. Examples of DET Courses

The following example aims, objectives and timetables are from training courses delivered in recent years. They should give an idea of how the issues and content can be put together to form a training programme and should give you an idea of the variety and potential of DET. More general information on how to design a training programme is available in the section entitled 'Sample exercises'.

○ **Example 1: One day DET for staff working with young disabled people**

Aims

To develop an understanding of the Social and Medical Models of Disability and their relevance to developing anti-discriminatory practice in your organisation.

Objectives

- To understand disability as a form of social oppression.
- To identify terminology related to disabled people.
- To explore the ways in which imagery of disabled people perpetuates oppression.
- To explore and challenge the charitable ethos which surrounds disabled people.
- To develop action plans which relate to short-term objectives.

Time	Contents
10.00	Welcome & introductions
10.30	'Sticks & stones...' (words associated with disability/disabled people)
10.45	'Names will never hurt me...' (positive/negative words & definitions)
11.15	Coffee
11.45	'Never ending story...' (causes of disability & impairment)
12.15	'Every picture...' (images exercise)
12.45	Lunch
01.30	'Freedom...' (barriers & solutions to independent living)
02.00	'Ring in the changes..' (making change—happen - barriers/solutions)
02.30	'A change for the better...' (completing action plans)
03.15	Questions & Answers/Evaluation/Summing Up
03.30	End

○ **Example 2: One day DET for local authority staff**

By the end of the course, Participants will:

- gain an understanding of the importance of appropriate and inappropriate disability terminology and imagery;
- be able to differentiate between Social and Medical Models of disability;
- be able to identify work practices and policies that are both consistent and inconsistent with the Social Model of Disability and the Disability Discrimination Act;
- have an understanding of how disabled people can be allowed to control their own lives.

Time	Contents
10.00	Introduction/Ground rules/Aims & Objectives
10.30	The Importance of Words – pairs & feedback
11.00	Break
11.15	Images of Disability – 3 groups
12.00	Power and Control – small groups
12.30	Lunch
01.30	Power and Control – feedback
01.50	Independent Living and the 7 Needs – group exercise
02.20	Disability Discrimination Act 1995 – presentation & questions
02.45	Break
03.00	Identifying Barriers in your workplace (access, attitudes & policies)
03.45	Evaluation
04.00	Close

○ **Example 3: Two-day programme for social services staff**

Aim

For workers in social services settings to understand the importance of the Social Model of Disability in their work and to identify strategies to influence and change current work practices with regard to local disabled people who use these services.

Objectives

By the end of the course, participants will have:

- Investigated attitudes towards disabled people and concepts of disability

- An understanding of the Medical and Social Models of Disability & disability terminology
- Established the links between the oppression of disabled people and that of other groups
- Explored the concept of independent living and the implications for professional working with disabled people
- An understanding of the notion of choices and rights and how it all fits into good practice within the community care legislation
- Identified real ways of implementing good practice following the Social Model of Disability into their daily work practice.

Day 1

Time	Contents
10.00	Introductions & Warm-up
10.30	Where does disability come from? Exploring the real problem (small groups)
11.15	Coffee
11.30	Re-defining disability – video & comments
11.45	Models of disability – analysing conflicting view of disability – presentation
12.30	Disabled people self-defined 'in our own words' – examination of materials
01.00	Lunch
02.00	Images of disability – various workshops exploring images of disabled people
03.00	Coffee
03.15	Terminology and Labels – Why so important? A different approach (group work)

- 03.45** **Community care and the models of disability** – Group exercise redefining assessment questions and practices within a Social Model context
- 04.30** Close of day 1
-

Day 2

Time	Contents
10.00	Warm-up: Empowerment thru the Social Model – group exercise
10.30	Case study to understand the links and parallels with other oppressed groups
11.15	Coffee
11.30	Independent Living vs. Care – wordstorm + small group exercise + feedback
12.15	Examples of good practice – role play pairs
12.45	Lunch
01.45	Rights & Legislation – presentation and practical application exercise
02.45	Advocating for change – video and discussion
03.15	Coffee
03.30	Action plans – individual and work group approach
04.20	Evaluation of course
04.30	Close of course

○ **Example 4: course outline for one-day DET**

Aims of the course:

- To dispel some of the myths and assumptions surrounding disability and disabled people.
- To reach a Social as opposed to a Medical Model of Disability.

- To explore the barriers disabled people face and find solutions.
- To develop practical action plans in order to implement change.

Course Content

- True or False
- Some facts, figures and information about disabled people and discrimination.
- Disability Terminology
- Language and terminology – why it is important to understand what is acceptable/unacceptable.
- Barriers to Equality
- A workshop highlighting the barriers disabled people encounter with an opportunity to discuss solutions.
- Social vs. Medical Model of Disability
- An exercise exploring the difference between the traditional view of disability – the Medical Model, and the view disabled people have adopted – the Social Model.
- Followed by a discussion on why the latter is fundamental in working together to ensure disabled people's full and equal participation in society.
- Workshops
- An opportunity to explore various disability issues, for example, the role of charity, imagery and independent living, through a series of participatory exercises.
- Action Plans
- A chance for participants to put today's learning into action by applying it to their work and lives.

○ **Example 5: Half-day DET course**

Aims of the course:

- To examine the barriers that disabled people experience from a Social as opposed to a Medical Model of Disability.
- To develop a practical understanding of disabling and empowering language surrounding disabled people.
- To identify opportunities and responsibility for individual and organisational change.

Time	Contents
9.30	Introduction & Welcome
9.45	Disability means....? A chance to explore how much we really know about Disability and Disabled people.
10.45	Coffee
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 & their experiences.
12.30	A Change for the Better A chance for participants to put today's learning into practice.
01.00	Goodbye!

○ **Example 6: One-day DET/DDA course**

Aims of the Course:

- To increase understanding of the discrimination faced by disabled people.
- To examine the effects of the Disability Discrimination Act (DDA) and its ability to address this discrimination.

Objectives

- To understand disability as a form of social oppression.
- To be able to identify and tackle the obstacles and barriers which prevent disabled people living independent lives.
- To understand the scope and limitations of the Disability Discrimination Act in relation to the rights of disabled people.

Time	Contents
10.00	Introduction: Ground Rules/Aims & Objectives/Warm-up Exercise
10.30	What is a disabled person? – pairs
11.00	The Social & Medical Models of Disability – presentation & discussion
11.30	Break
11.45	The Disability Discrimination Act's definition of disability: presentation & terminology exercise
12.30	What is discrimination? – pairs
01.00	Lunch
01.45	Disabling Barriers – small group exercise
02.15	The Disability Discrimination Act 1995 – presentation & questions

03.00	Break
03.15	Theory into Practice – Beyond the D.D.A.
03.45	Evaluation
04.00	Close

○ **Example 7: Course outline for one-day DET/DDA**

Aim

To increase knowledge of the Disability Discrimination Act 1995 and its implications.

Objectives

- To gain an understanding of the meaning of disability in relation to discrimination.
- To impart key features of the DDA in relation to employment and goods facilities and services.
- To consider the Act's implications for employees/employers and/or providers of goods, facilities and services.

Course Content

- Understanding Disability
- An introduction to the Social Model of Disability and some facts and figures regarding disabled people in the UK. An opportunity to put the DDA into context.
- Video
- A short introductory video highlighting key features of the DDA.
- The Disability Discrimination Act

- An 'up-front' presentation using OHPs introducing the three major components of the Act:
 - Prohibition
 - Reasonable adjustment
 - Justifiable discrimination

- Reasonable Adjustment
- A small group workshop examining reasonable adjustment in more detail. Using realistic examples participants will be asked to identify reasonable adjustments to be made.
- Linking Theory to Practice
- A workshop integrating learning to work practice in order to develop clear commitment to personal, professional and organisational action to ensure compliance with the DDA.
- An opportunity to produce action plans and a checklist of good practice.

○ **Example 8: Half-day DET/DDA course**

Aims of the course:

- Gain an understanding of the meaning of disability and current disability issues.
- Impart key features of the DDA in relation to employment and service provision.
- Consider the practical implications for employers and service providers to take the training forward.

Time	Contents
1.00	Introductions
1.15	Understanding Disability
1.50	What is Disability?
2.00	The Medical Model says ...
2.30	Coffee
2.45	DDA Presentation & Questions
3.15	Reasonable Adjustments in Your Workplace
4.00	Links to Practice
4.20	Evaluation
4.30	Close

■ 13. Sample Exercises

Whilst the example programmes give an idea of the process, timing and typical general content, this section includes some basic example training exercises.

Many DET trainers use similar methods and techniques and some of the following are commonly used exercises which should give you an idea of how to go about designing your own exercises or adapting existing ones. There are also some sample exercises in the course programme for 'understanding disability' and in the next section, general tips for designing training are discussed.

Finally, a warning against any method which involves participants imagining what it must be like to have an impairment as this individualising approach belongs in the hands of the disability awareness trainer and is not done by any competent DET trainer.

○ **Warm-Ups**

A warm-up may be a game to help participants relax. It may be an opportunity for people to introduce themselves and each other and for trainers to gain information about the group e.g. the different job titles/roles of people in the group, level of existing knowledge, hopes and fears or previous training attended.

○ **Ground Rules**

You can word-storm group ground rules, discuss in groups and then give feedback, give a prepared list of ground rules which can be read out loud or you could write a RESPECT model on the flipchart and go through each aspect: e.g. Responsibility, Energy, Support, Punctuality, Equality, Confidentiality and Talk, one at a time.

○ **Barriers Workshop**

This exercise can be done with small and large groups and is a useful way of drawing out and documenting the knowledge that people already have. By drawing on their own perceptions of how disabled people are discriminated against, participants can build a list which begins to identify the extent of this discrimination. It therefore becomes clear where the real problem of disability lies, focusing people's thinking and leading them into defining disability in a social context rather than by impairment.

- Group 1: Word-storm the organisational barriers which disabled people experience (e.g. legal system, education, class structure etc.)

- Group 2: Word-storm the environmental and access barriers which disabled people experience (e.g. environment, buildings, information etc.)
- Group 3: Word-storm the attitudinal barriers which disabled people experience (e.g. negative attitudes and assumptions.)

○ **Rights Exercise**

In groups, consider and write down your responses to the following:

- What do we mean by rights?
- In a general sense, what are considered to be the rights of people in society?
- What are the differences between civil rights / human rights / entitlements? Can you give an example of each?
- What blocks and barriers may stop disabled people from having these rights?

In a large group, feedback and discuss.

○ **Example of a Social/Medical Model Presentation**

Many DET trainers develop their own way of introducing the Social and Medical Models of disability to participants. The following is an example of the types of issues you might want to raise when presenting the models in training.

Models are developed in order to understand the way society works. Disabled people developed the Social Model in order to challenge the view that we are in a constant

state of illness and that it is our impairments/bodies/minds and senses which are the problem – the Medical or individual model of disability.

Describe the differences in the models in a basic way and ask the group questions to draw out the meaning and differences between the models.

Examples might include:

- What does the MM concentrate on? What is it trying to achieve – its aim?
- What does the SM concentrate on? What is it trying to achieve – its aim?

You could then sum up and clarify the differences in the models.

○ **Some Social/Medical Model discussion points and group work ideas**

The following are some questions which you could ask of small groups or to the whole group to begin to get people to question their common knowledge about disability.

Why not draw up 2 or 3 questions about a topic such as education and make this into a workshop where a small group go away and discuss the questions and then return and tell the others what they've said?

Each small group could have a different topic to consider e.g. the role of charity, media, independent living, other oppressed groups?

- Think about where information is found and what barriers there are to accessing the information – e.g. does the library have books & info on tape, where would you get info. translated into Braille?
- Why are disabled people segregated?
- Why do disabled people travel on vehicles marked 'ambulance'?
- Why are so many of the buildings difficult for disabled people to get into?
- Who designs buildings?
- Why do you think wheelchair users are expected to be accompanied when they visit a theatre or cinema?
- Are there other leisure facilities that are difficult for disabled people to use? e.g. swimming pools, clubs, football games etc.
- What would need to change for disabled people to be fully successful in mainstream education? Think about access, attitudes of parents/children/teachers/governors, training and policy issues.
- Why are disabled people not expected to achieve in employment? Why is it so hard for disabled people to gain equal access to employment? Think about the recruitment process, attitudes of employers etc.

○ **Re-defining Disability**

Part 1:

In pairs or small groups, get participants to consider:

What is disability? What is impairment? Who are disabled people?

Flip chart feedback and distinguish between Medical/Social Model responses.

Part 2:

In big group, split (or have two) flip chart(s) and list:

causes of impairment	disability means...
accidents	segregation
medical negligence	discrimination
violence	inaccessible transport
acts of God	lack of information
hereditary	poor education
self harm	prejudice
stress	poverty
wars	negative assumptions

Using the answers given (as above) in the big group, consider the following: In a world where there is the political will and the resources, go through 'disability means ...' and list and cross of those we can eliminate (given time, money and political will). Now go through 'causes of impairment ...'.

Most, if not all, of the barriers under the 'disability means' heading will be removed but few, if any of the causes of impairment will be removed. Ask participants, what conclusion can we draw from this exercise? We will always live in a world where impairment is natural yet we need not live in a disabling world. Rather than spending time and resources on eliminating impairment, we can – should – work together to break down the disabling barriers which prevent us from taking part in ordinary, everyday life. This is the Social Model of Disability – focus away from the individual, responsibility in the hands of society and promoting change, equality and inclusion.

Part 3:

Using all this learning and new information, in same pairs/groups as before, come up with a simple Social Model definition of disability by completing the sentence: "Disability means..." or "The Medical Model says...".

Change these statements from the Medical Model problems into Social Model solutions.

Example:

"I can't go out with my friends because my cerebral palsy stops me from getting on the bus." (Medical Model problem)



"If the bus was accessible, I could go out with my friends." (Social Model solution)

1. I can't go to the same school as my friends because I can't get up the steps in my wheelchair.
2. I can't read books, magazines or newspapers because I can't see.
3. I can't go to my local cinema because my spina bifida means I am a fire hazard.
4. I can't be on the youth club committee because I can't hear.
5. Because I can't speak clearly, I can't make friends.
6. Now try and think of your own example.

○ **Empowerment through the Social Model**

In pairs or small groups discuss the benefits of viewing disability in a Social Model way – why is a Social Model

definition of disability so positive for disabled and non-disabled people? Flip chart benefits.

○ **Language**

In a large group, word-storm all the words that come into your head when you hear the word 'disability'. Discuss language issues before moving on to second part of the workshop. In small groups, consider the following pairs of words:

- Wheelchair bound / wheelchair user
- Care / Assistance
- Suffers from... / Person with...
- Carer / Personal Assistant
- Disabled person / person with a disability
- able-bodied / non-disabled

For each pair, consider: Is there a difference? Does it matter? Discussion and feedback.

○ **Media Images**

List examples of positive and negative images of disabled people under each of the following headings:

GOOD / BAD

- Books
- Films
- TV
- Adverts
- Charity Advertising

In groups, provide participants with a selection of charity images of disabled people and ask them to consider:

- what image of disabled people do the text and picture convey?
- what emotions or attitudes do the adverts exploit?
- what is the purpose/s of the advert?

○ **Stereotypes of Disabled People**

Below are 8 of the most common media stereotypes of disabled people. For each, list an example of a book, advert, film, TV or radio programme which shows disabled people in this stereotypical way:

- Pitiable and pathetic (eg. Children in Need / Tiny Tim in Dickens' Christmas Carol)
- Objects of violence (eg. Whatever Happened to Baby Jane)
- Sinister or evil (eg. Richard III / Freddy from Nightmare on Elm Street)
- Super cripp / Triumph over tragedy (eg. newspaper articles / Heidi / sports coverage)
- Laughable / Comic (eg. Mr Magoo / Hear No Evil, See No Evil)
- Chip on shoulder (eg. One Flew Over The Cuckoos Nest)
- Burden / Outcast (eg. Snow White and the 7 Dwarfs / Beauty and The Beast)
- Non-sexual / Incapable of having relationship (eg. Lady Chatterley's Lover / Coronation Street)

○ **Images of Disability**

The following prompts could be used to generate whole or small group discussions around images of disability:

- Where do we see disabled people in the media?
- How are disabled people portrayed?
- What kind of images are used? What type of language?
- What messages about disabled people do you get?
- Where are these attitudes/stereotypes from?
- What input, if any, do you think disabled people had in this process?
- How much do you think negative attitudes towards disabled people are generated by media coverage?
- Are disabled people getting representation that is fair, equal, free from stereotyping, according dignity?

Explore how disabled people are portrayed/represented in society – look at where information about disabled people comes from, who is in control of it, who defines what language is used and why. Aim at an understanding of the way in which language and imagery can be very oppressive, but also very positive and powerful. Look at powerful, active images of disabled people that contradict the tragedy/fear/super cripp stereotype.

○ **Evaluation**

A quick round-up at the end of the training asking participants what they learnt/enjoyed/disliked or the filling in by each participant of what are commonly called 'happy sheets' are two common ways of gaining initial feedback.

However, more meaningful evaluation methods might for example focus on the relevance of the training during the weeks following the course.

Trainers may use their own form, training organisations/networks will most likely use their own evaluation methods or the purchaser may prefer to use their in-house forms.

An example happy sheet for the end of the course might ask the following questions:

- Which particular session did you find useful and why?
- Which particular session did you NOT find useful and why?
- What has been the single most important aspect of the course for you?
- Is there anything you think should have been covered that wasn't?
- What action will you personally take in order to use the training in your work?
- Other comments

■ 14. Disability Art Training: An Overview

Disability Art Training is essential for all arts, artist and arts-funding bodies as it is something which few people understand and which is beginning to become a dominant form of arts culture for disabled people.

Disability art is a new challenge to traditional art thinking and practice which is both a major step forward in the understanding of disability and in the use of art in understanding precisely what disability is (not impairment).

Disability art is very different in conception to what disability and art are, and in comparison to what art therapy is. Key distinctions need to be made so that all people involved in arts fully understand what they may be saying about disability and art per se. It is not about creating a hierarchy but about facilitating a more effective and comprehensive understanding of what one is precisely saying as one says it. So often we use the terms interchangeably when they are very different in process, practice and intent.

Disability Art is a particular use of art practice, process and philosophy that is intrinsically entwined with the philosophy of the Social Model of Disability. It uses art to explore what disability is: the result of social processes; it has nothing to do with the individual pathology or the coping mechanisms of individuals. It is not about facilitating their understanding and comprehension of their own impairment. Though it may well be used to facilitate and understanding of the Social Model of Disability.

Art therapy, on the other hand, is purely about doing art for therapeutic reasons. It is about facilitating an individual to learn to cope and understand their own psychological situation in relation to any pathological processes that may be inhibiting their developmental processes as either an individual or in relation to a particular focus group (familial, for example). Often, and this is a major criticism of it in relation to disability, it places disability within the individual and reinforces the false idea that disability is a pathological condition (which it is not; that is, to be more precise, an impairment).

Art and disability, is merely art which is done by disabled people that has neither a therapeutic nor a political or social dimension to it.

The distinctions is for the sake of clarity and not to articulate either an hierarchy or a negation of one form in relation to another.

■ 15. Effective Action Planning

Comments relating to the effectiveness of DET sometimes include:

- "I'm powerless to change things."
- "Already overworked, I've now got more to do."
- "I know a bit more, can tick the disability box."
- "It's just tokenism and won't lead to real change."
- "It's not relevant to me or my job."
- "It's not me that needs this but my boss."

Such comments are justified if there is no real product or change as a result of the course and if participants are left with new ideas, frustrations and enthusiasm but without guidance and support. DET courses can demonstrate the barriers and discrimination that exist for disabled people but cannot effect any fundamental change unless those involved in the training process at all levels commit themselves to a programme of action. For this change to begin to happen in DET, it is essential that there is a structure within which it can take place.

Therefore, every DET course should devote a period of time to developing a disability action plan that is relevant and achievable at both the personal and organisational level. Trainers can use their expertise to identify realistic goals and make appropriate referrals for further info or consultation to ensure successful completion of participants action plans. Without action, training is pointless and any effects or good intentions will be lost.

A written action plan might include the following headings:

- Subject: the broad area you have picked out for improvement;
- Goals: agreed specific targets you wish to achieve;
- Problems: barriers are you going to encounter;
- Solutions: how deal with the barriers;
- Activities: list, sequentially, steps to bring about the change;
- Time: indicated time period steps (specific dates if possible).

Short-term action plans for change should be SMART (Specific, Measurable, Achievable, Realistic, Time Limited).

■ 16. Developing Your Own Material

Potential material is everywhere, e.g. website on the internet, newspaper cuttings, magazine articles, leaflets, adverts, TV and radio programmes. Cut things out, keep things you see, keep your video at the ready and a tape recorder available for recording radio programmes. A clip of TV coverage or a magazine article might become the basis for a whole exercise by asking questions and getting participants to consider the issues raised. It is important to keep updating information and resources on disability.

Always work from the aims and objectives as the starting point rather than churning out the same materials regardless of the aims and objectives. If you find something that works, great but as a starting point, always ask yourself “what do I want participants to know and have learnt by doing this exercise?” Once you’re clear about the outcomes of an exercise, then you can be clearer about how best to ensure you meet them.

Simple can often be best. New trainers in particular have a tendency to want to dream up the most elaborate and clever techniques when simply asking people to discuss in pairs “What disables people?” can lead to detailed responses allowing you to examine the models of disability!

Many trainers use similar materials and similar approaches to exploring the core issues of DET. As long as you meet the aims and objectives of the training, don’t worry if other people do things the same way as you do or differently to you. Each trainer brings own style and strengths and that distinguishes trainer from trainer.

Sharing ideas and using tried and tested materials which meet the aims and objectives of DET are a good idea. The reality that training is a career, however, may lead some trainers to copyright materials whilst others will be happy for their work to be shared, copied and used. As a matter of good practice, therefore, you could ask the trainer permission to use and adapt their ideas and methods.

You could use material that someone else has prepared and designed; for example, you can buy some ready-made training packs from both organisations of disabled people and mainstream training providers. If you use materials that you haven't designed and don't personally 'own', you usually need to adapt them and add your own style to them in order to feel comfortable using them and for the materials to be as effective as possible.

Don't be afraid to try new things; just because you've always done something one way doesn't mean it's the best way!

The 'best way' is one which is effective in passing on the information and enabling the participants to learn about disability equality: for example, by using more 'creative' training methods, participants could show the differences between the models of disability through pictures, drama or song.

Part 2

The Philosophies Behind DET: Disability and the Disabled People's Movement

LIZ CARR & PAUL DARKE

This section provides a basic introduction to some of the principle beliefs behind DET and the growing social empowerment of disabled people and places DET within a broader social context.

■ 1. What Disables People?

To really understand the importance and basis of Disability Equality Training we need to look at what we mean when we talk about disability. Who are disabled people and what is it that disables people?

The disabled people's movement makes a key distinction between impairment and disability.

Impairment: What is 'wrong' with that disabled person?

Focusing on the impairment by asking what is wrong with the disabled person, is to take an individual or Medical Model approach to disability.

Disability: What is 'wrong' with society?

Focusing on disability by asking what is wrong with society and why it excludes disabled people, is to take a Social Model approach to disability.

Therefore, from a Social Model perspective impairment is a characteristic, feature or attribute within an individual which is long-term and may or may not be the result of disease or injury. Disability, on the other hand, is the disadvantage or restriction of activity caused by a society which takes little or no account of people who have impairments and thus excludes them from mainstream activity.

Thus, disability, like racism or sexism, is discrimination and social oppression. Impairment belongs to and is owned by

the disabled person, disability belongs to and is imposed by society.

For example, an inability to walk is an impairment whereas the inability to get to the first floor of a building because there is no lift is a disability. An inability to move one's body is an impairment but an inability to get out of bed because suitable physical help is not available is a disability.

Disabled people are people with impairments who are disabled by society.

■ 2. Models of Disability

Models are frameworks that help us understand the problems of 'disability' and help us understand the best solutions to 'disability'. There are two main models to consider when looking at disability, the Medical/Individual Model and the Social Model. DET, the Disabled People's Movement and many others use the Social Model of Disability.

The Medical Model of Disability sees disability as an individual problem, as a personal tragedy; the way that most people in our society, including many disabled people themselves, view disability. It is sometimes called the Individual model of disability. The Disabled People's Movement, via the universities, have developed a very different way of looking at disability. Using the Social Model of Disability. The Social Model identifies the problems and solutions of disability as re-defined by disabled people, based on our expertise and direct experience. As it

implies, disability is re-defined as a social (not individual) problem/issue.

○ **The Medical Model of Disability**

- Views the body as sick or defective, describing disabled people as ill and in need of treatment.
- Believes the individual disabled person is the problem and sees difficulties experienced as being caused by the individual impairment/condition.
- Views the solution to these problems as cure. The individual is offered therapy, medical aids or operations to enable them to become as 'normal' as possible and fit into society.
- Views the problem of disability as medical and therefore the solutions and expertise rests in the hands of the many medical and disability professionals All areas of a disabled persons life are specialised and medicalised.
- Is used by governments, local authorities, the NHS, charities, the World Health Authority, etc as it is the dominant and for many, highly profitable, model of disability.

The Medical Model says:

- I cannot get involved in the youth club committee because I cannot hear.
- I cannot go to my local school because I use a wheelchair and it has lots of steps.
- I cannot get a job because my cerebral palsy stops me getting on the bus to get to work.

The Problems with the Medical Model are:

- Disabled people who do not respond to the treatment can feel failed by the system and even personal failure.
- Disabled people are viewed as a burden on society.
- Disabled people are viewed as 'having something wrong with them.'
- Millions of pounds are spent with little achieved for disabled people.
- By focusing on 'curing' the individual, society remains unchanged, the status quo remains.

○ **The Social Model of Disability**

- Understands disability as a problem created and imposed by society. People with impairments live in a hostile, disabling world designed to suit non-disabled people.
- Recognises that disabled people face systematic discrimination in the way society and its institutions are organised, by the way the environment is constructed and by the attitudes values and beliefs that develop as a result of the systematic exclusion of disabled people from mainstream society. Disability is a human rights issue.
- Draws attention to the barriers created by society and promotes solutions based on the knowledge that if disability is created, then it can be removed without having to change the person or curing the individuals impairment (in many case this is not possible or desirable). Impairment is a reality of life but disability need not be.

- Establishes disability as a form of oppression experienced by people with impairments. This allows the Disabled People's Movement to make links, exploring the commonalities and differences with other oppressed groups.
- Lifts the blame from the shoulders of disabled people and places it squarely onto society, thereby liberating and politicising disabled people to challenge society to remove those barriers.
- Comes from disabled people's own experiences and is the basis for all organisations run and controlled by disabled people who promote rights, equality and inclusion for ALL people.

The Social Model says:

- I cannot get on a bus because it is not accessible. I cannot find work because employers will not give me an interview because of my speech impairment.
- I can't live independently because not enough accessible homes are being built or because my local council will not pay for the help I need.

○ **Some Effects of Disability (from the Social Model)**

Disabling attitudes e.g. fear, pity, repulsion, hatred, superiority, there but for the grace of god, charity cases, incapable, asexual, deviant, lives not worth living, courageous, childlike, marvellous, chip on shoulder, in need of cure, a burden, 'special', victims, 'touched by god', tragic, bitter, abnormal ...

Special/segregated provision in education, housing, employment, transport and many other services means

that from an early age, disabled and non-disabled people will be separated from each other. Until we are included in society on our own terms and in our own right, discrimination will continue.

Disabled people are on average three times more likely to be out of work than non-disabled people and many will have to rely on benefits for their basic income.

Poverty is the greatest disabling factor for the majority of disabled people.

Many disabled people may not be able to access information if their education levels have been limited or perhaps access to materials in a tape, large print Braille or computer disc format is not available.

Table: The Medical Model of Disability vs. The Social Model of Disability

The Medical Model	The Social Model
Individual Diagnosis Treatment 'Special' Provision Therapy Professionals Research Care Cure Ill/Sick Rehabilitation Integration Normality 'You must Change'	Collective Access Choice Independent Living Attitudes Information Action Rights Equality Role Models Change Inclusion Difference 'Society must change'

■ 3. The Language of Disability

“I’m embarrassed, I never know what to say ...”

These are common things said during DET during the language and terminology sessions. Trainers need to understand the importance of language and definitions of disability when faced with responses ranging from defensiveness, to relief, to a misguided belief that if ‘acceptable’ language is used, then that will change the world! Words without action for change are meaningless: people may call you a disabled person but if their actions reveal that they treat you like an invalid then all a change of language has achieved in this instance is to gloss over their deeply ingrained disabling beliefs by giving an appearance of acceptance and enlightenment. This maintains discrimination, rather than challenging it.

“Language is always changing ... I can’t keep up!”

Examples of words masking the truth of disability include the use of the word ‘home’ to describe residential institutions or use of the word ‘special’ which, when added to any service concerned with disability, becomes synonymous for segregated.

“Does it really matter: it’s all PC nonsense anyway!”

A backlash against political correctness has led to language issues being an annoyance for many and a joke to others. This minimises the powerful political importance of the words we use to define ourselves and our experience of

disability. It is not about being "politically correct", it is about having respect for people, valuing people and using the language, which they themselves have chosen to define their situation. In the same way that minority ethnic groups, gay people and other oppressed groups have identified the power of language in the promotion or racism, sexism and heterosexism, disabled people understand the way words perpetuate and maintain disablism.

"I know disabled people who call themselves handicapped."

Disabled people have taken control over defining the problem of disability, so too has the Disabled People's Movement taken control over the language used to describe ourselves and our experiences.

"They bite your head off if you say the wrong thing."

By taking back words that have been imposed upon us, by using new words or by redefining meanings, a new language of disability has been created to reflect this shift in power.

■ 4. Acceptable Terminology

Acceptable doesn't mean 'sounds nicer'.

Acceptable doesn't mean 'politically correct'.

Acceptable certainly doesn't mean words which individualise or medicalise the experience of disability. Acceptable language are those terms which disabled people have chosen themselves in the process of self

definition and which are situated within the Social Model; locating the focus of disability where it belongs, squarely upon society as a whole.

Terms to Avoid	Use Instead
Handicapped Wheelchair bound Confined to Wheelchair Arthritic/Epileptic Spastic/MS Sufferer Invalid (means not valid) Mentally Handicapped Mentally Ill (Nutter/Loony) The Blind/Blinkies The Deaf (and Dumb) Fun Runner/Able-bodied	Disabled person Wheelchair user Wheelchair a Mobility Aid "Person who has ..." People, not a Condition Disabled person Learning Disabled Mental Health System User Visually Impaired Person Deaf People Politically Unconscious

■ 5. No to People with Disabilities

○ Disabled People vs. People with Disabilities: Disabled People's Views

Disabled people and their organisations, use the term Disabled Person, because we are disabled by society not by our impairments. This articulation and terminology is based on the Social Model of Disability; using definitions coined by Disabled People's International in 1981 and subsequently adopted by the British Council of Disabled People - BCODP.

Disabled People refers to ALL disabled people, regardless of their specific impairment as it is the commonality of

the experience of disability which unifies us as disabled people.

To label yourself a Disabled Person is (often) a political statement, in exactly the same way that "Black" is a positive assertion of identity in a racist society.

A good parallel is seen when we consider black people. Black people are not "people whose skin tone is different to that of the dominant culture", nor are they people who achieve things despite their "blackness". The term "black" is a politically motivated identity of a group of people who recognise that: a) they are proud to be the way they are, including skin colours, cultures and languages and b), they belong to a group of people who are systematically oppressed by the dominant culture which is white: i.e., by racism.

○ **People with Disabilities (oh no!)**

Some people use the term "people with disabilities" because it puts the person first and is more politically correct than handicapped person. From a Social Model perspective, however, this term is inaccurate, individualistic and it blurs the key distinction between impairment/disability.

Used like this, the term 'disabilities' refers to medical conditions, which from a Social Model perspective, disabled people define as 'impairments'. People do not "have" disabilities like attachments compelling them to live different lives. Society disables people by creating or approving barriers to their inclusion or participation.

What is actually meant when one uses the term 'people with disabilities' is 'people with impairments'.

The distinction is essential for the sake of clarity so that you, us, we, all know what we talking about.

■ **6. The Disabled People's Movement**

The Disabled People's Movement in Britain has its roots in the late 1960s and early 1970s when more and more people started openly identifying themselves as disabled people, developing their own ideas on what it meant to be disabled and working together to demand change. Few people realise, however, that disabled people have a rich history of uniting for political and social change which dates back over 100 years. To educate others about our current situation, it's essential to understand the history of disabled people's self-organisation.

A few key dates:

- 1890 The British Deaf Association was formed – the first campaigning group controlled by disabled people.
- 1899 The National League of the Blind – a trade union, began and became affiliated to the TUC in 1902.
- 1920 250 people marched to London in a demonstration organised by the National League of the Blind, to force through a law concerning benefits for disabled people.
- 1964 In America, large numbers of disabled ex-servicemen returned from the Vietnam War unable to go back into mainstream life and began to question why.

Disability became a civil rights issue in the USA at this point – but not in the UK.

- 1973 A letter was written to the *Guardian* asking people to write of their experiences of residential care in order to form a network and a pressure group for change.
- 1974 The Union of the Physically Impaired Against Segregation was formed and began to define the problem of disability as one which was socially created. Their paper, 'Fundamental Principles of Disability' documented the distinction between impairment/disability, became the blueprint for collective, campaigning organisations and formulated informal discussions into a formal analysis of the Social Model of Disability.
- 1981 The International Year of Disabled People in 1981 saw the formation of the British Council of Organisations of Disabled People (now the British Council of Disabled People) and during the same year, Disabled People's International was formed – this was the official recognition of the Disabled People's Movement.

The first coalition of disabled people was established in Derbyshire – a campaigning organisation controlled by disabled people, based on the Social Model of Disability and committed to the full inclusion of disabled people.

○ **Organisations 'of' Disabled People**

Groups run by disabled people for disabled people are often where we first come together to organise and campaign for change. There are however times and places where

disabled people come together and nothing changes – if our energies are conveniently sidetracked into basket weaving and Bingo, we are not going to build the strong group identity we need to fight the discrimination that we face daily. Unified groups of disabled people based on a Social Model vision of breaking down the barriers which create disability are called organisations ‘of’ disabled people, meaning that they have at least 51% of their management control in the hands of disabled people.

These groups are mostly local Coalitions or Centres for Independent Living (CILs) working on local issues which have from 51 – 100% management control by disabled people and many are run and staffed by majority or all disabled people. Organisations ‘of’ disabled people are the foundation of the disabled people’s movement.

○ **The British Council of Disabled People (BCODP)**

The British Council of Disabled People was set up by disabled people in 1981 to promote the full equality and participation of all disabled people within society. As well as having an individual membership scheme, BCODP is an umbrella organisation that represents over 130 organisations ‘of’ disabled people at the national level. It is the only national umbrella organisation to be democratically set up by disabled people, to represent their interests at the national level, to be founded upon the Social Model of Disability and as such, is the heart of the Disabled People’s Movement in the UK. BCODP is also part of the world disabled people’s movement through its membership of Disabled Peoples’ International (DPI). Worldwide, our movement encompasses millions

of disabled people linked through the struggle for equal rights, a common experience of discrimination and a collective identity.

○ **Organisations 'for' disabled people**

The majority of organisations associated with disability are charities and are not part of the disabled people's movement. We call these organisations 'for' disabled people because they are not run and controlled by disabled people, by the people they claim to be working for.

These organisations are based on a Medical Model approach to disability, raising money to help us be as normal as possible, using images of us to raise money in our name and maintaining segregation, paternalism and a who-knows-best approach towards disabled people.

Unlike the Disabled People's Movement, charities divide and rule us into categories based on our impairment groups. They are not accountable to nor representative of disabled people and maintain a charitable rather than rights based approach to disability.

The conflict between organisations of and for disabled people can be neatly summed up in the disabled people's movements slogan "rights not charity". This is at the root of the way in which most organisations of disabled people will not work with the Leonard Cheshire Foundation, for instance, and ask all other organisations and individuals to boycott the Leonard Cheshire Foundation.

○ **The Role of Charity**

In 1351, the English government passed a law called the Statute of Labourers which made it illegal for people to give money to beggars capable of working. If those beggars were disabled people, however, the law did not apply and it was perfectly legal to give them money as it was assumed disabled people couldn't work. Disabled people's unequal treatment and dependence upon charitable handouts has, therefore, been enshrined in law in England for over 650 years!

Begging is perhaps a little more sophisticated today, but many would argue that little has changed; with the cutting back of public services, there is an increasing reliance on charitable benevolence to provide very basic services and opportunities. The charity trap places disabled people in a position where they must plead poverty and suffering to receive a share of the spoils that are raised in our name, forced to collude with and maintain the misrepresentative fundraising image of our lives.

It is an issue of power – who has the power to say what we need, to say how we should be presented to the public, and to say how money raised in our name should be spent. Non-disabled people make these decisions with little reference to those of us whose very existence has given them their jobs and their salaries.

This is further evidenced by, as stated above, the way in which most organisations of disabled people deal with the Leonard Cheshire Foundation, the biggest, richest and most powerful of the organisations 'for people with

disabilities'. They clearly understand little and only exploit disabled people. To give you an indication of the difference in status: the amount the Leonard Cheshire Foundation spends in a month on public relations is more than the BCODP's annual funding.

■ **7. Issues of Independent Living**

○ **Independence**

The traditional definition of independence insists that you 'do as much as you can for yourself' and perform 'normal' basic daily tasks before you are allowed to taking your place in society. Disabled people, many of whom require assistance and who have experienced this tyranny of independence, believe it to be a form of oppression. In keeping with the Medical model, it individualises disability, placing the onus on disabled people to cope and adapt in a society designed to meet the needs of non-disabled people. Redefining independence means that it is not about doing everything for yourself, coping on your own or not needing other people's help. Instead, independence is simply about having choices and being in control of what happens to you.

Everyone, disabled or not, relies on other people, and is interdependent on other members of society: you can be independent and yet need people to assist you with the practicalities of life.

○ Independent Living

Independent Living is a liberating concept that has its roots in the Disabled Peoples Movement's struggle from the 1960s onwards, to develop effective alternatives to residential care and traditional individualistic services for disabled people requiring assistance. Independent living is about all people, regardless of their impairment or assistance needs, having choice and control over their lives and an equal opportunity to fully participate in the economic, social and political life of their community:

"Independent Living is the ability to decide and to choose what a person wants, where to live and how, what to do and how to set about doing it. These goals or decisions about a person's life and the freedom to participate fully in the community have been and will continue to be the essence of Independent Living. It is also the taking and establishment of self-determination in the total management of a person's everyday life and affairs". (d' Aboville, E. 1991)¹

This means not only the right to have control over basic daily living tasks – such as when to get up, go to bed, go to the toilet, when and what to eat – but also the right to have personal relationships, to be a parent, to have equal access to education, training, employment and leisure activities and the right to participate in the life of the community. Independent living therefore encompasses the full range of human and civil rights. Centres for Independent/Integrated Living (CILs).

1 d' Aboville, E (1991) 'Social Work in an organisation of disabled people' in Oliver, M (ed.) Social Work: Disabled People and Disabling Environments, London, Jessica Kingsley.

○ **Centres for Independent/Integrated Living (CILs).**

The growth of the Disabled People's Movement, the development of the philosophy and practical application of independent living and a growing demand by disabled people and their organisations for greater involvement in the development and running of their services, led to the emergence of the first CIL being opened in Derbyshire in 1985. CILs are community-based organisations providing a range of services for all disabled people which are controlled and run by disabled people themselves. They are based on the Social Model of Disability and exist to provide flexible and responsive solutions, not dependency creating services.

The National Centre for Independent Living, part of BCODP, provides a unified voice with influence to promote independent living issues nationally – most notably through the years of campaigning leading up to the passing of the Community Care (Direct Payments) Act 1996.

○ **The Seven (7) Needs of Independent Living**

Whilst each CIL will provide different support and services, they will be based upon the commonly identified 7 basic needs which if met, would enable true independent living:

1. Information
2. Peer Support
3. Housing
4. Aids and Equipment
5. Personal Assistance
6. Transport
7. Access

In addition to these Seven (7) Core Needs; some organisations of disabled people have identified the following areas as essential for full and meaningful participation in society:

1. Inclusive Education and Training
2. An Adequate Income
3. Equal Opportunities for Employment
4. Advocacy (towards self-advocacy)
5. Appropriate and Accessible Health Care
6. Direct Payments
7. Personal Assistance

If, as a society, our environment and services were developed to meet these basic needs, we would be building a society that includes and in which the social causes of disability would be slowly eliminated.

○ **Direct Payments**

The unique feature of Independent Living and direct payments is that they were designed and developed by disabled people who required assistance and wanted 'cash for care' instead of traditional services. As giving cash directly was illegal, for over 20 years, increasing numbers of disabled people received indirect payments to buy in the personal assistance they required for living. The effectiveness of these creative schemes and of the Independent Living Funds ensured the success of the campaign to legalise direct payments.

The Community Care (Direct Payments) Act 1996 allows Social Services to offer disabled people a direct cash

payment instead of the community care services they have been assessed as needing. Disabled people can use this money to buy in the personal assistance they require.

○ **Personal Assistance**

Personal assistance makes independent living a reality for many people. Traditionally, the need for personal assistance has been seen as a need for 'care' – a need to be looked after and then the 'carer' became the person in charge or in control. The term Personal Assistant (PA), rather than 'carer' is used to make clear the working relationship wherein the disabled person is the employer of the PA and in control of the assistance provided. Personal assistance means that disabled people exercise the maximum control over how services are organised and custom-design their services according to their individual needs, capabilities, life circumstances and aspirations. In particular, personal assistance requires that the disabled person decides:

who is to work;
with which tasks;
at which times;
where and how.

By opening up access to a full range of life choices, personal assistance can enable disabled people to transform their social identity and reclaim their citizenship. A Personal Assistant is therefore the means by which a disabled person exercises choice and control and achieves Independent Living.

■ 8. Disabled People in History

Historically, disabled people have been viewed with a variety of emotions including hatred, ridicule and pity. They have been systematically murdered, persecuted, laughed at and, until fairly recently excluded almost completely from the economic and social life of the community. The following simplistic look at key phases in history, serves to illustrate the creation, development and maintenance of 'disability' through the ages.

From the earliest of times within Christian thinking the idea of sin and disability has been linked. The implication is that disability is a punishment for our sins or the sins of our fathers. It is only by examining such myths that we can begin to question these values upon which British society was founded and still operates.

Throughout the Bible, the emphasis has been towards cure and healing physical and sensory impairments in an attempt to achieve 'wholeness'. This concept has a clear correlation with the familiar, more modern, 'Medical Model' of disability by implying that impairment is a personal tragedy which necessitates cure or care.

Prior to the industrial revolution, the care of disabled people was on the whole within their own community with their non-disabled peers. Many were forced to beg 'cap-in-hand' on the streets to survive, while others were cared for by their extended families. It was considered shameful to have a disabled person in the family and private care, a luxury of the middle classes, served to enable some to conceal this shame.

The beginning of mass production introduced during the industrial revolution and, with its resulting sale of labour, began the wholesale segregation of disabled people. Society changed from centring around working on the land to around working in factories. The machinery and technology which swept the country was designed to be operated by non-disabled people. This created a very clear dividing line between those who could contribute and those who could not. This meant that disabled people became progressively isolated from their peers and, as the extended family gave way to the nuclear family, it became difficult for disabled people to remain in the family environment.

The morality of Dickens's times wanted beggars off the streets. Workhouses for the poor, 'asylums' for the 'mad' and institutions (crippleges) for Disabled people came into being. As these institutions grew in number and size and the staffing in some areas became professionalised, they had to be maintained – thus growth of the charity business with its non-disabled benefactors and the consequent decline of Disabled people into a sub-section of society who required care and pity.

The 19th century saw greater segregation of disabled people. The workforce had to be more physically uniform to perform routine factory operations. As work practices, towns and services were developed and standardised, disabled people became further segregated from society. Increasing mechanisation also meant that more people acquired impairments through accidents at work. Disabled people were rejected, were viewed as worthy poor as opposed to work shy and thus given poor law relief. At

this time, disabled people became dependent more and more on the medical profession for cures, treatments and benefits.

World War One had a major impact on the image and treatment of disabled people. Many who had served their country in the War came back with impairments, so the idea of 'rehabilitation' was introduced to get these people back to some sort of 'normality'. It was after the Second World War when the first piece of legislation using the term 'disabled people' was used and laws relating to employment, education and welfare services were passed to assist disabled people to be integrated into what had now become an alien environment. Medical and professional dominance, segregated services and charity benevolence were now firmly established.

And the rest, as they say, is history...

○ **Images of Disability**

To be a disabled person is to exist within a society where your image and identity are created by beliefs, values, myths, assumptions and stereotypes based on the individualistic Medical Model of Disability reducing our experiences to personal tragedy. Our culture is replete with disablist imagery which keeps the ancient fears and prejudices which surround impairment alive. Where do we get our images of disabled people? Our information about their lives? Where do we as disabled people find role models and images of ourselves in the mainstream media?

○ **Stereotypes**

Children grow up associating physical impairment with the malice of Captain Hook and go to bed with images of the crippled witch from their story book. Film makers use mental illness to portray wickedness and the word disabled becomes synonymous for impotence, hopelessness and social inadequacy. Charity images, children in need, local newspaper campaigns to raise money for little chips for electric wheelchairs, call us victims, tell the world what we're 'suffering' from – all in the name of fundraising. The following, for example, are eight (8) commonly held media-maintained stereotypes of disabled people found in literature, television, newspapers and film:

1. Pitiable and Pathetic (i.e., children in need / Dickens (e.g. Tiny Tim in Christmas Carol)
2. Objects of Violence (i.e., Whatever Happened to Baby Jane)
3. Sinister or Evil (i.e., Richard III / Freddy Kruger in Nightmare on Elm Street)
4. Super Crip/Triumph over Tragedy (i.e., newspaper articles, Heidi, sports coverage)
5. Laughable/Comic (i.e., Mr Magoo, Hear No Evil, See No Evil)
6. Chip on Shoulder (i.e., One Flew Over The Cuckoos Nest, news coverage)
7. Burden/Outcast (i.e., Snow White and the Seven Dwarfs, Beauty and The Beast)
8. Non-Sexual/Incapable of Having Relationships (i.e., Lady Chatterley's Lover, Coronation Street)

Imagine, you turn on the television one evening; the news coverage is of a scientific breakthrough to help people with spinal injury to walk again; there is an advert for a major enabling charity asking for your money to help those less fortunate; the most popular soap has a newly impaired character who deserves all he gets as he was a bad guy and then the film at 9pm has a major Hollywood star triumphing over tragedy in his Oscar winning performance as a disabled person.

What are the messages we get from such images? Messages about the quality of our lives, of our existence, of our value as disabled people? Messages which are easy on the eyes and ears as we sit and watch TV but which relate action, prejudice and discrimination. That our lives are not worth living is a deeply entrenched belief upheld by the media, by society's responses to disability and by our history. A history where disabled people have been segregated into institutions. A history where the Nazi Action T4 Euthanasia Programme killed over 170,000 disabled people designated as life unworthy of life. A history where across the world, millions of disabled people have died from unrecorded neglect. The assumption that our lives are not worth living is so deeply held that few people question it as they watch the repeat of this view night after night on TV.

○ **Charity Images**

Charities, through their fundraising efforts, create images which prevent the recognition of disabled people as human beings whose lives have value. In competing with each other for public cash, charities create a kind of brand

awareness of the particular group of disabled people who they purport to represent. Advertising which focuses on impairment and turns the attention away from the disabling effects of society. The messages are clear: disabled people are their condition, they are imprisoned by their abhorrent minds and bodies and confined by their wheelchairs as they wait for the public's benevolence to cure them or give them a life.

Charities and their advertising agencies create the kind of images which they think are going to encourage non-disabled people to give money. They try to create images which evoke pity or feelings of guilt: the act of giving money becomes an insurance policy, an unspoken, thank god it's not me or my child. Criticisms that charity campaigns demeaned disabled people were met with a change from black and white to colour images and increased consultation by disabled people in the creation of charity images. Is this really progress?

○ **Disability Culture**

When the images around you do not reflect your experiences, the only option is to create your own culture. Disabled people have done just that, taking over the words which undermine us and using them to empower us and finding new ways of describing our lives. This is what we are doing when we insist that the word 'disability' describes what society imposes upon us. This is what we are doing when we reclaim the word 'cripple' and made 'crip' our own, in much the same way as 'queer' has become part of gay and lesbian culture. This is what we are doing when we create our own poetry, stories, theatre, music and humour.

The explosion of disability arts in the last 20 years is not about 'positive images' – that's the non-disabled world's attempt to make us normal, believing that it's somehow progressive to pretend that we are like them. No! Our bodies look different, behave differently and we do not have to aspire to be normal to develop ways of representing the reality and value of our lives.

Disability arts is about representing the world from our point of view. It's about using humour to attack the institutions which oppress us. It's about using theatre to rage against the difficulties we face. It's about using photography to celebrate our differences. It's about using words to document our experiences and the richness of our thoughts and lives. It's about songs which leave you "proud, angry and strong".

○ **Disability as an Equal Opportunities Issue**

Using the Social Model of Disability, it is clear where discrimination takes place and what measures need to be taken to eradicate it. We must therefore talk about disabled people having equal status and opportunities within society – equal opportunities and access to transport, housing, education, leisure – in fact, everything that makes up the world in which we live. In this way, links can be made with other groups in society who experience oppression as a result of their difference and deviation from what is considered 'normal'.

○ **Experiencing Oppression**

Many groups of people within society experience discrimination for reasons ranging from impairment to gender, to sexuality, to colour, to culture, class, age, education to name just a few. Discrimination occurs when prejudice is put into action and unequal treatment is the result. Anyone and everyone can be discriminated against at some time or other as we act out our prejudices. Certain groups of people, however, experience oppression i.e. the systematic and institutional discrimination of one group by those who hold the power to deprive people of social and economic privilege. Sexism for example, refers to the oppression experienced by women from men, and disablism is the the oppression experienced by disabled people from non-disabled people. There should be no hierarchy of oppression, one is not worse than another, simply that the response to them varies.

Whilst all forms of oppression are not the same and do not have the same historical roots, there are many links and similarities between how different oppressions are experienced on a day-to-day basis.

The type of discrimination experienced by disabled people is much more than individual prejudice, being institutionalised within the very fabric of our society. The oppression disabled people experience is detectable when the policies and activities of all types of modern organisation result in inequality between disabled people and non-disabled people. This oppression is rife throughout British society, causing the overwhelming majority of disabled people to experience extreme economic and social hardship every day of their lives.

○ **Multiple Oppression**

Too often, the oppression of disabled people is viewed in isolation. It is important, however, to remember that disabled people are women, black people, gay people, are from different class backgrounds, different cultures, varying ages etc. Disabled people may, therefore, be effected by racism, heterosexism, sexism and other forms of oppression which will conspire and compound to ensure disabled people remain on the fringes of society.

■ **9. Civil Rights for Disabled People**

○ **The History of Disabled People's Campaign for Civil Rights**

The history of the campaign for civil rights for disabled people is the history of the Disabled People's Movement and of the development of the Social Model of Disability. The Disabled People's Movement, since the early Eighties, has been focused on the campaign for comprehensive anti-discrimination legislation (ADL) to enable disabled people to participate fully in the mainstream economic and social life of the community. Disability, as redefined by disabled people through a social approach, is now a rights issue.

BCODP conducted research and produced 'Institutional Discrimination Against Disabled People: A Case for Legislation', the first major study to deal with the problems faced by people with impairments within the context of institutional discrimination, and it was the first to be conceived, sponsored and written with the full co-operation

of disabled people and their organisations. It demonstrated what disabled people knew by experience, that systematic institutional discrimination is a reality of every aspect of their lives. The need for an Act to outlaw discrimination and begin to dismantle the disabling barriers experienced by disabled people thus became a collective goal of the Disabled People's Movement, giving a framework for local and national campaigning, lobbying and direct action.

○ **What do We Mean by Rights**

Human rights, for example reproductive rights, are those rights we have or should have as a human being, because we share that right with all human beings, and because human beings need that right in order to exist as individuals and as a species.

Disability is a human rights issue and the Disabled People's Movement works to campaign for the recognition and protection of our most basic needs and rights to life, existence and humanity. As of October 2000, these rights are directly protected in British law through the Human Rights Act 1998.

Civil rights, for example the rights of access to buildings, are those rights we have as a citizen to participate in public life because all citizens have those rights equally, and these rights are often protected in British law. An example of a law protecting civil rights would be the Disability Discrimination Act 1995 but the inadequacy of this law, other laws and societies responses to disability means that disabled people do not have legally protected civil rights to equal citizenship and participation.

Entitlements, for example, the right to practical assistance in a person's own home, are those rights which are specific to a group, e.g. older people, children and disabled people, which other citizens do not have. In this way, an entitlement is a gateway to civil and human rights which otherwise could not be accessed. Many entitlements are laid down in laws e.g. the Chronically Sick and Disabled Persons Act 1970 or in charters, guidance documents, policies, standards and so on. At a basic level, the failure to acknowledge these basic entitlements is an infringement of a person's civil and human rights.

○ **The birth of the Disability Discrimination Act 1995 (DDA):**

Whilst the first Civil Rights (Disabled Person's) Bill was drafted with the full participation of disabled people and their organisations and introduced by Lord Ashley in 1982, successive governments fought against the need for ADL, arguing that there was little evidence of widespread discrimination against disabled people; based on the dominant individualistic approach to disability, everyday difficulties encountered were linked to a person's impairment and any rare cases of disadvantage were seen as best dealt with by educating to change attitudes, not legislating to ensure rights.

Modelled on the Americans with Disabilities Act 1990, the inclusive and comprehensive Civil Rights Bill had cross-party support and but still the resistance to see disability as a rights issue prevented its enactment. After 17 attempts and considerable political pressure, in November 1995 the Government's Disability Discrimination Bill became an Act of law.

The DDA was not the legislation disabled people had been demanding for over a decade but instead was reluctant legislation with hurried consultation. This factor has undoubtedly shaped the Act – many definitions are restrictive, justifications for discrimination are broadly defined and businesses with less than 15 employees are exempted. Whilst it is an achievement that disability has been recognised as discrimination and entered the legal arena as a rights based issue, the Act can be summed up as one which protects some rights of some people in some situations at some times.

The Disabled People's Movement in general remains unimpressed with the DDA, claiming that it is inadequate, not comprehensive and despite the launch of the Disability Rights Commission in 2000, is largely unenforceable. Disabled people continue to campaign, the goal being civil rights legislation which removes the barriers that confront disabled people in mainstream education, the built environment, transport, housing and the health and social support services. In other words, comprehensive ADL similar to that in the USA, Canada, New Zealand, parts of Australia and several of our European partners.

○ **The Human Rights Act (HRA) 1998**

It is a common myth that the introduction of the Human Rights Act 1998 (HRA) will grant us all more 'rights' in the most basic but essential areas of existence. Since October 2000, the HRA has incorporated the European Convention on Human Rights into UK law. This means that the rights we've had protected through the Court of Human Rights in Strasbourg for the last 50 years will now also be protected

and enforced through UK courts and tribunals. The Act doesn't create new rights, it just brings them home and should therefore make them more accessible.

You cannot use the HRA against another individual who may infringe your rights as the Act only covers the behaviour of public authorities. These include Government departments, local authorities, the police and also covers the public functions of organisations such as Railtrack, private schools and charities which provide services on behalf of local authorities.

In order to bring use the Act, a person must be the 'victim' of an unlawful act. An organisation or interest group, e.g. a disability organisation, can bring a representative action on behalf of others if it is able to name all those affected. It can act as a 'friend of the court' arguing on behalf of a party who is unrepresented.

Where a case is successful, a court may grant any remedy that it considers appropriate, including financial damages, an injunction stopping something happening or a declaration of rights.

The Rights protected by the Act are:

- Article 2 Right to Life
- Article 3 Prohibition of Torture
- Article 4 Prohibition of Slavery and Forced Labour
- Article 5 Right to Liberty and Security
- Article 6 Right to a Fair Trial
- Article 7 No Punishment Without Law
- Article 8 Right to Respect for Private and Family life

- Article 9 Freedom of Thought, Conscience and Religion
- Article 10 freedom of Expression
- Article 11 Freedom of Assembly and Association
- Article 12 Right to Marry
- Article 14 Prohibition of Discrimination
- Article 1 of Protocol 1 Protection of Property
- Article 2 of Protocol 1 Right to Education
- Article 3 of Protocol 1 Right to Free Elections
- Article 1/2 of Protocol 5 Abolition of the Death Penalty

The use to which the HRA will be put by disabled people is still unknown but what is significant is the increasing acknowledgement of rights, bringing human and civil rights into arena of media, public authorities and the general public. Will it be yet another situation where using the right words will serve to obscure the real issues of discrimination or will the HRA actually make a difference?

○ **The Disability Discrimination Act**

The DDA is written within the Medical Model and talks of 'normal' values. It specifies physical impairments and mental impairments, yet is vague or totally avoids appropriate definitions, leaving large parts of the legislation to interpretation and misunderstanding. Had the Social Model of Disability been used to frame the new legislation, acts of discrimination may have been clearer to define. Such a definition would have concentrated on the way that an individual is disabled by society, through the identification of barriers to integration, independence and equal opportunities.

By defining disability in the medical context, discrimination in some areas becomes lawful, thus creating even greater confusion for everybody. Perhaps the most positive aspect of this law is the duty upon certain employers and service providers to make reasonable adjustments in relation to policies, practices and the environment which may prevent access to and participation by disabled people. Whilst this is subject to tests of reasonableness, it is nonetheless a recognition of the barriers disabled people experience and acknowledges the duty to remove them.

There are 2 main sections within the Act:

Goods and Services

This covers anyone who provides 'goods or services' i.e. shops, restaurants, cinemas, etc (education and transport are excluded). For example, a restaurant would be expected to make 'reasonable adjustments' if it was 'unreasonably difficult' for a disabled person to make use of their facilities. Discrimination in relation to the letting of premises is also covered under this section.

Employment

This section covers recruitment, training and promotion. For example, if an employer treats a disabled person (for a reason relating to their 'disability') less favourably than someone who does not have a 'disability', they may be found to have contravened the DDA, unless the employer can show the treatment was justified.

Definition

The Act defines a disabled person as someone who 'has a physical or mental impairment which has a subsequent and long-term adverse effect on his ability to carry out day-to-day activities'.

Other areas covered by the Act

The Act also includes disabled people's right not to be discriminated against in the provision of premises. Although transport and education are not specifically covered by the DDA, the Government has now drawn up regulations for new land based transport, the latest date for accessibility being 2017.

The current Special Educational Needs Bill, if passed by Parliament will extend the DDA to include educational establishments, giving disabled children a stronger but, significantly, no absolute right to mainstream education.

Part 3

For DET Trainers/ Facilitators: What Next?

LIZ CARR & PAUL DARKE

As an experienced trainer, perhaps this book has been a useful re-cap of issues and methods. If you've been on a course and wanted to learn more, hopefully the disability issues and resources elements of the book will have helped you develop your understanding of the politics of disability. If you were and are still interested in DET and would like to know more about becoming a trainer, this section is for you!

■ 1. Qualifications for DET Trainers

At the time of writing, there is no standardisation of DET, no register of trainers and no national accredited trainer training course for disabled people. The issue of accreditation, accountability and consistency in DET are currently being discussed within the Disabled People's Movement whilst in the mean-time non-representative organisations and educational establishments are setting up DET training-the-trainer courses that may not be accountable to the Movement.

Basically, therefore, there is currently no set pattern to becoming and to working as a disability equality trainer. The great thing about this lack of structure is that rather than adapting to an inaccessible process of qualification, disabled people's organisations are creating their own.

Education has discriminated against many; turning this reality into a qualification means the experience of such oppression and exclusion becomes the major criteria for being a DET trainer.

In a similar way, whilst mainstream training events and methods have mainly excluded disabled people, isn't this the perfect opportunity to develop methods which are inclusive for all, in line with the creativity of the Social Model of Disability?

■ **2. Essential Skills**

Only those who directly experience disability as a form of social oppression will really 'know' the subject matter of DET thoroughly enough to teach about its reality.

As a result of this, it is believed that DET should only be carried out by disabled people equipped with training techniques and a thorough understanding of disabled people's lives from a Social Model of Disability perspective.

○ **Training Techniques**

Including facilitation, design and delivery skills, these are useful for anyone involved in training, regardless of the subject matter. It is not enough to know your subject matter. You also need the skills, confidence and opportunity to be able to pass this knowledge on to other people in a way that impacts upon them and leads to change. Only 'Training the Trainer' courses run by organisations of disabled people are likely to combine general training techniques and disability issues. However, local voluntary or disability organisations and your local colleges are likely to organise general courses for trainee trainers. From a day to a few sessions, right up to nationally accredited full-time courses, there are lots of opportunities to develop traditional training skills.

○ **A Social Model of Disability Perspective**

I.e., know your subject matter! Being a disabled person gives you first-hand, direct experience of living in a discriminatory society but being a disabled person is not in itself enough

of a qualification – too many disabled people sit in front of a group and spill out their personal history in the name of disability awareness. Disability equality is about all disabled people and is about the Social Model of Disability. Do you, for example, know about segregated education if you went to mainstream? Or do you know how the Disabled People's Movement developed? You need to know your stuff because that is the knowledge you will be passing on to participants.

Get involved with your local organisation of disabled people, chat with other disabled people and attend any disability issues/personal development type courses they may be running. Why not while away some hours on the net looking at the many disability sites, subscribe to magazines produced by organisations part of the Disabled People's Movement and if you have the opportunity, ask to observe other disability equality trainers to learn ideas and techniques. You can attend a disability equality event for a day or you can complete a course at university in disability issues but whatever you choose to do, you need to keep up to date and aware of current debates.

Beware of who is running the course. With general skills it is less important who runs the training, as long as it is accessible training which meets the outcomes you expected. With disability related training, however, it must be training rooted in the Social Model of Disability if you are to become a DET trainer.

■ 3. Training the Trainer Courses

A number of organisations of disabled people run Training the Trainer courses which cover both of these elements, providing disabled people with the basic knowledge, skills and support to become a DET trainer.

Such courses date back to the mid 1980s when disability equality was being developed in line with the growth of the Disabled People's Movement; the London Boroughs Disability Resource Team began to formalise the development of DET, running training the trainer courses, leading to a network of trainers and producing the first DET trainers guide.

Many disabled people have attended this course and the guide became somewhat of a blueprint for many trainers. Since this time, other organisations of disabled people have developed Training the Trainer in Disability Issues Courses and a number of organisations have trainer forums and sub-groups where as well as essential support, issues of ongoing development and local issues can be raised.

Contact your local organisation of disabled people to find out if they have a training group, if they run DET training the trainer courses or if they can recommend other local/national resources. To find your nearest organisation contact BCODP, details in the Resources section.

■ 4. Still Want to be a DET Trainer?

You've been on a training the trainer course and now you want to get out there and do your stuff ...but how?

It's important to gain as much and as varied experience as possible, working with people, shadowing, co-training, perhaps a training mentor to work with you as you gain in experiences until you are ready to work on our own or as a lead trainer in your own right.

It may be that the organisation you trained with offer further opportunities for development, otherwise, there are a number of training networks and groups which vary in their aims: for example, providing training the trainer courses, hosting a register of trainers, being an 'agent' for work and subcontracting consultants to provide DET on behalf of the network and providing opportunities for less experienced trainers to shadow and co-train.

Training networks tend to be based either on location e.g. regional networks of DET trainers, or on subject matter e.g. national networks/registers for those who specialise in education, independent living, etc.

■ 5. Employment Options

For someone starting out as a trainer, being involved with a network or organisation of disabled people is a good way to gain the experience and apprenticeship you need before you feel confident enough to move into freelance work. They often find work for you, provide co-training

opportunities and will assist you with contracts and invoices and payment issues.

Sometimes payment varies depending on your level of experience, from shadowing to co-trainer to lead trainer rates, for example. When you train for an organisation of disabled people, you representing them and training on their behalf and usually a portion of the payment will be ploughed back into the organisation to sustain and develop the training programme.

Many trainers are or become self-employed freelance trainers. This means that they are responsible for all the aspects of training – from the marketing and getting the work, to planning and liaison to designing and delivering the course and organising payment. You are responsible for your finances, including tax and national insurance on the money you earn.

Often, disabled people will freelance, yet be involved with different organisations and networks in order to gain both experience in different areas and, of course, to gain employment.

■ **6. Marketing Yourself**

If and when you go down the road of freelance work, you will be responsible for your own marketing, your own public relations and to sell yourself, your ideas and skills to those looking for training. Even if reputation, word of mouth and informal contacts lead to work and opportunities, you will need to somehow communicate such information as what you're offering and what you expect in return.

When you've worked out what you want to tell possible purchasers of your training, you need to decide how you're going to do that. If someone has already approached you for more information then business cards, compliments slips, headed paper, a CV, a leaflet, etc might be things you want to consider. If you're trying to attract business, then apart from a leaflet, standard letter of introduction and a promotional website, you might want to put an advert in the press, contact local organisations and offer your services or look in the disability press for adverts asking for training tenders or bids for work.

Work often leads to work, so always make sure that when you run a course, that the participants have some information and details about you so they may contact you in the future.

■ 7. Promotional Material

○ Creating a Promotional Leaflet

A promotional leaflet about what you provide can be as simple as a side of A4 paper with typed information which should include:

- a brief summary of what type of training you provide;
- personal statement about who you are;
- who you have and do provide work to;
- the core philosophy of your training/company;
- methods used;
- costing and what this includes/excludes;
- minimum and maximum numbers;
- access requirements; and
- contact details.

For example:

Dr. DET offers a wide selection of Disability Equality Training courses that range from a half day to two days in length. Individual programmes are designed to meet the requirements of specific agencies – including voluntary and statutory organisations, private companies and local authorities. The promotion of the Social Model of Disability, in contrast to the Medical one, is a central theme that runs through ALL the Dr.'s training. The use of videos, group workshops, discussion and the sharing of experience are some of the techniques employed.

Dr. DET is a disabled man who has been training in the field of DET for 64 years. His insight into the issues which affect disabled people are a direct result of life experiences. His career to date has included training for Hitler, Leonard Cheshire, Hodge the Bodge, Blunkett's Cripilage and Duttons Fruit and Veg Shops.

Dr. DET's training fees:

One day course £350

Two day course £650

Half day course £175

Consultation 1 hour @ £30

A reduction in training fees for voluntary organisations and organisations of disabled people can be negotiated.

Fees include initial programme consultation and course materials but do not include travelling expenses or accommodation.

A maximum of 15 and a minimum of 8 is the ideal number of participants on any of the courses offered. All training premises must be wheelchair accessible and provide a television, video recorder, flip chart and stand.

For further information please contact Dr. DET at the above address or ring/fax 01666 666 666.

■ 8. Fees

Self-employed trainers working for local authorities usually charge between £250 and £400 per person, per day.

There are people who charge much more but especially if you are co-training, this scale is about the right one. In the private sector the accepted amount paid for training will be higher and at the other end of the scale, voluntary organisations will have little funding available for courses.

For too long disabled people have been asked to give their expertise and skills for nothing and many organisations seem shocked that DET is a job and not an unpaid hobby. It is important therefore not to undersell yourself but to make sure you are paid a decent wage and expenses which show that what you are offering and providing is of value and is a professional service. If you undercharge, you will not be valuing the going rate and your skills and questions of professionalism may be asked when your application, proposal or tender is being considered.

On the other hand, overcharge and you price yourself out of consideration.

Always make sure you are clear to them about what are fees and what are expenses.

Usually, the fee covers course design and delivery materials and information packs whilst expenses cover travel, accommodation and personal assistance costings where relevant.

Some people like to include these as hidden costs in the fee they charge whilst others include them as expenses.

■ 9. Contracts

Once you've been successful and have secured work, you may have a contract between yourself and the organisation who are purchasing your services. Very few organisations actually provide contracts, but if they do, they will include more or less everything from your fee to contact details, dates and responsibilities.

The majority of people purchasing your training will be much less formal and give you nothing at all. In this case, it would be up to you to decide if you want to devise a semi-formal agreement for them to sign, including costings, named contact person and cancellation arrangements.

If they have not discussed cancellation terms with you, you may wish to put this in your agreement. It is normal practice to ask for a proportion of the payment in the event of their cancellation, depending on how close to the course they cancel. But if the course is re-arranged to a mutually convenient date, then you could waive the usual terms.

An example of a cancellation agreement might be:

- within 3 weeks of the course - 25% of agreed fee
- within 2 weeks - 50%
- within one week - 75%
- below minimum number of attendees or on the day - 100%

If you work for a network or if you are training on behalf of an organisation, then your contract will be between them and you rather than with the purchasers of the training. Unlike most organisations, DET networks have much more consistent and reliable contractual arrangements.

Do get advice on your employment status if you are just embarking as a trainer, from an independent advisor. Some organisations that employ you as a freelance trainer may well take off tax and insurance if you do not jump through all the hoops in proving you are self-employed with a Schedule D Number – each organisation seems to have its own system and way of doing things.

No matter what, you must get yourself organised by keeping all your accounts carefully, with proper invoicing of work and receipts for petrol, accommodation, materials, stationary etc.

An invoice should include the following:

INVOICE		
Name of Customer	Invoice No.	
Schedule D No.	Invoice Date	
Date of course	Details of Invoice	
20 May 2001	Disability Equality Training	350.00
	124 miles @ .35p	43.40
TOTAL		£393.30
Please make cheques payable to Dr DET and send to the above address.		

* Schedule D No: Tax reference number in the UK.

If you are moving more and more into training, it is advisable to use an accountant unless you are personally skilled in this area. If you are training on a very occasional basis, if you have other employment or if you are benefits, you are best getting advice on how you should proceed regarding course fees.

None of these situations mean you cannot be a paid trainer, but it is just a little less straight forward.

Again, if you are working for a network of disabled trainers, it is likely that they will advise you and may be able to assist you through the benefits, traps, etc.

■ 10. Checklist and Payment

○ Pre-course Check List

Whether or not you have a contract, the following check list is a useful reminder of all the pre-course information and arrangements you might need to agree:

General

- The client (organisation) is;
- Address / phone / fax / email;
- Contact person and phone number;
- Course title;
- Date/s of course;
- Time course begins / ends at;
- Contract;
- Cancellation agreements;
- Fee & payment arrangements;

- Evaluation form provided by;
- Venue / refreshments / course materials and equipment;
- The venue for the course;
- Client to ensure accessibility of venue;
- taking issues of accessibility into account;
- Parking Seating Food / drink / other;
- Break times;
- Refreshments provided by;
- Will client photocopy materials (who pays / provided).

Client to provide

- Flip chart stand and pads, flip chart pens, TV and video, OHP, other;
- Material in accessible formats: Braille, large print, tape, disk;
- Do we need an interpreter, other.

Participation

- Minimum number of participants;
- Maximum number of participants;
- Trainer needs list of participants and their roles by;
- Client will inform trainer of participants access needs by;
- Is the course compulsory or will people choose to attend;
- Is there a mix of job levels;
- Payment.

Do get advice on your employment status, if you are just embarking as a trainer, from an independent advisor.

Some organisations that employ you as a freelance trainer may well take off tax and insurance if you do not jump thru all the hoops in proving you are self-employed with a Schedule D Number – each organisation seems to have its own system and way of doing things.

Whatever, you must get yourself organised by keeping all your accounts carefully with proper invoicing of work and receipts for petrol, accommodation, materials, stationery etc.

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None of these situations mean you cannot be a paid trainer, but it is just a little less straight forward. Again, if you are working for a network of disabled trainers, it is likely that they will advise you and may be able to assist you through the benefits, traps, etc.

Part 4

Concepts Around Disability and Disabled People

KENJI KUNO

In this section, several models of disability and key concepts and notions around disability and disabled people are explored, namely, participation, social inclusion/exclusion and empowerment. Lately discussed comprehensive framework to analyse well-being of people, the Capability Approach of Dr. Amartya Sen, is also discussed as an analytical framework to examine the well-being or freedom of disabled people.

■ 1. Model of Disability

○ Introduction

Although DET takes the Social Model of Disability as its fundamental framework, it is worthy to explore potentials and limitation the Social Model and other models of disability. It is difficult to develop a universal definition of disability with simple statements, although various attempts have been made (UN 1999). This is because the perception and understanding of disability are formed through the influence of history, culture, and society, and it relates to all aspects of lives of people (Barnes 1994; Ingstad and Whyte 1995; Barton 1996; Barnes et al. 1999, 2002). In addition to this, terms such as “disability” and “handicap” have been given different meanings in different societies, and in different models of disability (WHO 1980, 2002b; Devlieger 1995, 1999; Nagase 1995; Pfeiffer 2000; Ustun 2001; Hurst 2003). It is important to bear in mind that understanding disability does not simply mean to understand disabled people. A number of other factors must be taken into account in the proper analysis of disability.

Various analytical models of disability have been developed in order to reflect the comprehensiveness and complexity of disability. The potentials and limitations of these models to analyse and understand disability were discussed and clarified by comparing a range of models employed by researchers (Altman 2001; Pfeiffer 2001). The comparative analysis of the bipolar models of disability has been central to the discussions of the understanding of the different views on disability, i.e., Medical Model and Social Model of Disability.

Based on such comparison in the 1980s and 1990s, several different views and models which shed light on the diversity of aspects of disability have been developed. Pfeiffer summarised and compared a number of these as follows: Medical Model, social constructionist version (U.S.), Social Model version (U.K.), impairment version, oppressed minority (political) version, independent living version, post-modern (post-structuralism, humanist, experiential, existentialism) version, continuum version, and the human variation version.

In addition to these, other models of disability were elaborated, notably the feminist model of disability and the activity space model of disability, or alliance model of disability (Lloyd 1992; Kopec 1995; Brett 2002). These comparisons were also not universal but are based on cultural background and history of disability and disability movements (Ishikawa and Nagase 1999; Ishikawa and Kuramoto 2002).²

Although a similar term, 'disability' (or disablement in some cases) is used in these models and views, it is used to mean various aspects of the issues which disabled people face in their lives. In other words, on the one hand it may be important to develop one single definition and apply it in order to clarify the core aspect of disability. On the other hand, it may be more useful to take various models and views of disability together with the understanding of the limitations of each model. This will facilitate a more comprehensive understanding of the issues and problems faced by disabled people.

2 For instance, "equalisation view on disability" and "differentiation view on disability" have been the key bipolar views in the discussion on disability in Japan.

In this section, the potentials and limitations of the following models were considered: 1) Medical Model of disability, 2) Social Model of Disability, 3) Synthesised Model of disability, 4) Differentia Model of disability which includes Social Model of impairments, Culture Model of disability, Affirmation Model of disability, Inclusion Model of disability, Post-Modern Model of disability, and 5) Family Model of disability (Table 1).

Models of disability are useful as a tool to understand different aspects of disability (Llewellyn and Hogan 2000). Models and views on disability do not exist in isolation but are developed for a number of reasons: as a critique, to support an approach, or in the development of a new idea or approach. The next section gives a very brief description of the evolution of some of the major models. By clarifying different views on each model of disability and its position to the other models of disability may help to illuminate key notions of each models of disability (Figure 1) By doing so, we are able to obtain a comprehensive view of disability.

Traditionally, disability was understood as fate or punishment in relation to one's beliefs and religion. It was also considered as an unchangeable condition. The Medical Model of disability dismantled this belief by defining disability as a physical and intellectual condition where change could be brought about by medical or educational interventions. It shifted disability issues from the moral and belief sphere into the realm of the natural sciences.

However, a strong emphasis on the physical aspect of disability in the Medical Model did not reflect the

Figure 1 : Different Models and Views of Disability

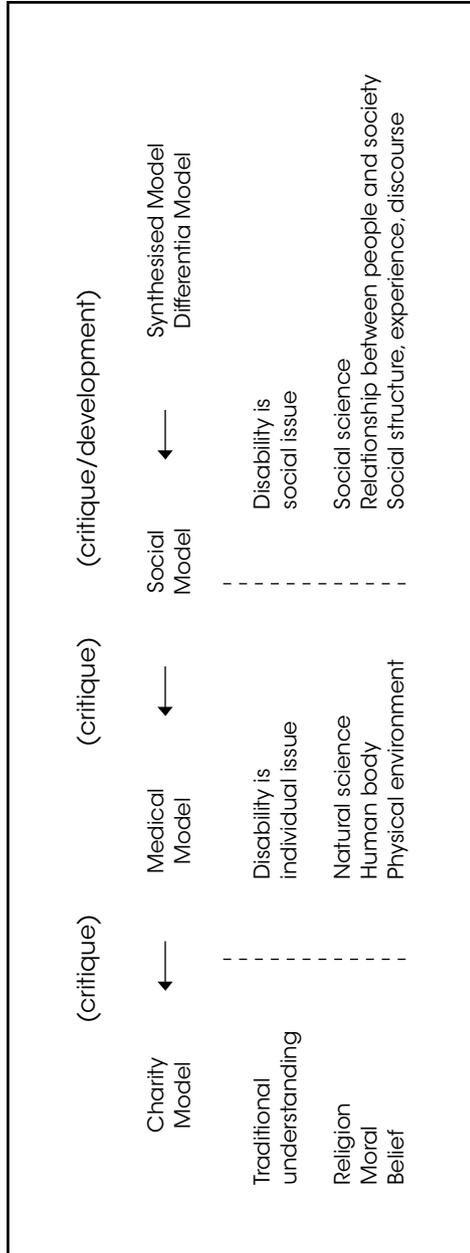


Table 1: Models of Disability

Model	Medical	Social	Synthesised	Differentia					Family
Sub-model	Nagi model, ICDH	Social constructionist & creationist views	ICF	Social Model of impairments	Culture model	Affirmation model	Inclusion model	Post-modern model	-
Views on Disability	Functional incapability	Discrimination & inequality	Participation Restriction	Personal experience of impairments	Cultural invasion	Negative attitudes	Social exclusion	Socially constructed	Burden
Disabled people	Abnormal	Discriminated	Unequal	Have different experience	Cultural minority	Unique	Everyone is different	Socially constructed	Including family
Focal issues	Functional independence	Social institutions	Functional independence & social structures	Experience	Culture	Attitude	Social barriers	Discourse	Experience
Intervention	Rehabilitation	Social change	Rehabilitation & social change	Dealing with individuals' experience	Positive separation	Affirmation of difference	Social inclusion	Discourse analysis	Intervention to burden

importance of the social aspects of disability. Although in some cases social aspects were considered in terms of “handicap”, all of the causes of disability were aggregated into physical and mental conditions.

Another change in perspective arose with the influence of civil rights movements and other social movements involving segregated people. Disabled people came to believe that disability is not mere physical or intellectual matter, but is oppression and segregation. Institutions and structures of society, which include attitudes of people and legislations, are identified as the causes of disability. This view developed by disabled people arose as a critique of the Medical Model became known as a Social Model of Disability. By shifting the focus to the interaction of people in society and social institutions, this model transformed the understanding of disability from issues of natural science into social science. However, three key characteristics of this model were criticised and other models were developed based on these criticisms.

The Synthesised Model of disability, which is the integration of the Medical and Social Model of Disability, was developed as a comprehensive model of disability by compensating for the limitations in each model.

The Differentia Model of disability pointed out the limitations of the Social Model, which focused only on the aspect of segregation and treated disabled people as a homogeneous group/category of people. Hence, it failed to reflect the various experiences or perceptions of disabled individuals, including the experiences of impairments that may not necessarily be an experience of

segregation or oppression. All of the above models identify disability only in relation to disabled individuals. However, the Family Model of disability claimed that disability is not only an issue for disabled people, but family members of disabled people as well. They too experienced disability in different forms and that required recognition, particularly since disability is no longer merely physical and functional issues but incorporates larger social issues as well.

○ **Medical Model of Disability**

The Medical Model can be explained by describing its three dominant characteristics: 1) it views disability as a personal problem and locates disability mainly within the individual; 2) it assumes the causes of the problems directly stemmed from health conditions, e.g. disease, trauma, functional limitations or psychological losses; and 3) it perceives medical interventions as the primary response to disability (Ustun 1998b: 4).

WHO developed the International Classification of Impairment, Disability, and Handicap (ICIDH) in 1980 as a tool for the classification of the consequences of disease, and defined disability within a linear causal linkage between impairment, disability and handicap (Box 1). This classification of disability is heavily influenced by this model of disability.

Box 1: Definition of Disability in the Medical Model

Impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function.

Disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or within the range, considered normal for a human being.

Handicap is a disadvantage for a given individual, resulting from impairment or a disability that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

Source: (WHO 1980)

This classification of disability has been widely accepted by rehabilitation professionals, hence by those in CBR. However, it has long been criticised and rejected by disabled people themselves. The major criticism is that it fails to see disability within the social context, and confines disability to physical and mental functions. In the terminology of the ICIDH, the focus is on the impairment of individuals as the ultimate cause of disability and perceives disabled people as passive objects rather than actors (Finkelstein 1992; Oliver 1994, 1996).

○ Social Model of Disability

The Social Model of Disability was developed by those active in the disability movement who viewed disability as social discrimination and oppression (UPIAS 1975: 14; Finkelstein 1992). The Union of The Physically Impaired against Segregation (UPIAS), a key organisation of disabled people in the UK, defined disability as follows:

Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. ...and disability as the disadvantage or restriction of activity caused by a contemporary social organisation, which takes no or little account of people who have physical impairments, and thus excludes them from participation in the mainstream of social activities (UPIAS 1975: 14).

DPI has opposed the ICIDH since its inception in 1981 by defining disability as follows (Box 2) (Oliver 1994: 63; Hurst 1998: 1).

Box 2: Definition of Disability of DPI

Impairment is the loss or abnormality plus the effect on function.

A **disability** is the disadvantage or restriction of activity caused by social factors which take little or no account of people who have impairments and thus exclude them from the mainstream of social activities.

From their own direct experiences, disabled people see themselves as disabled by the constraints and negative attitudes imposed on them by a discriminating society – not by their impairments or limitation (Hurst 1998: 1). They do not see the strong causal linkage between disability and impairment, focussing on what they perceive as the real causes of disabilities, discrimination and prejudice. Oliver (1996: 39) compared these two perceptions of disability and criticised the insufficient understanding of the Medical Model (Table 2).

Table 2: Comparison of Medical and Social Models of Disability

The Medical Model	The Social Model
Personal tragedy theory	Social oppression theory
Personal problem	Social problem
Individual treatment	Social action
Medicalisation	Self-help
Professional dominance	Individual and collective responsibility
Expertise	Experience
Adjustment	Affirmation
Individual identity	Collective identity
Prejudice	Discrimination
Attitudes	Behaviour
Care	Rights
Control	Choice
Policy	Politics
Individual adaptation	Social change

In this model, disability is seen wholly and exclusively as a social issue. Hurst (1998: 1-3) says that although there is no “normal” human person, disabled people are seen as different – as deviating from what is deemed the normal range of what makes up a human being. Therefore, the management of the problem requires social action, and it is the collective responsibility of society to make the environmental modifications necessary for the full participation of disabled people into all areas of social life. This model assumes not individuals but society should be changed, and this is part of the process of political empowerment of disabled people (Oliver 1996).

Critiques of the Social Model

There are also several critiques of this model or the dichotomy of models of disability. The first critique is raised by feminists and post-modernists (Devlieger 1999). The deterministic approach of the Social Model of Disability makes individual differences unnoticeable, and denies the recognition of different and unique experiences of disabled individuals (Shakespeare 1994; Barnes 1997; French 1997; Morris 1997; Oliver and Barnes 1997). Neglecting impairments in the Social Model of Disability, or to confine impairments within a bio-medical understanding is also criticised, and the need to understand impairments and its experience in the social context is raised (Abberley 1997b).

The second critique is strongly argued by those who consider themselves part of the Deaf culture. They were critical of the assumption within the Social Model which described the bodily or functional differences or

impairments as a negative attribute. Oppression can be justified by seeing physical difference as inferiority in reality (Werner 1992), and it also holds positive attribute as 'uniqueness'. The Deaf community emphasised their own cultural identity, based on the use of a language that is both unique and owned by them (Nagase 1995, 1996b, 1996a; Corker 1998; IDF 1999). Similar changes in perception or self-identification are seen in people with other impairments, by differentiating themselves by giving positive meaning to their body function and structure, not differentiated by others due to their impairments.

○ **Synthesised Model of Disability**

There has been an attempt to synthesise the polarised Medical and Social Models, which presented a thesis-antithesis proposition. It is hoped that a Synthesised Model would capture the interaction of the various dimensions of disability. The WHO revised the ICIDH and tried to synthesise the two major models into one comprehensive model of disability. In this process, the WHO recognised that the "pure" Medical Model, hence ICIDH, could not adequately address disability issues as a whole (Oliver 1996: 36; Ustun 1998a: 4). For this reason, a revised version of ICIDH, i.e., International Classification of Functioning, Disability and Health (ICF), has been developed (Ustun 2001; WHO 2002b).

ICF has been developed as a scientific tool to reflect the shift in paradigm from the purely Medical Model to an integrated Biopsychosocial Model. It aimed to provide various means to map the different dimensions and domains of disabilities (Ustun 1998b: 2; WHO 1998). Because it is meant to be a communication tool which

would neutralise the terminology, several terms have been dropped including 'handicap' (WHO 1998). ICF explains disability in terms of its interactive nature, rather than a linear causal relationship, and defined three dimensions of disability (Box 3, Figure 2).

There are several critiques of this attempt to synthesise the dominant models especially from disabled people's perspectives (Hurst 1998; Pfeiffer 1998). Major criticism is that despite its attempt to integrate with the Social Model, the underlying principles of medicalisation of disability remain in the synthesised mode. This is especially apparent in the conceptualisation of 'participation' which is still largely remaining in the domain of activities of daily living. In fact, the concept of participation is less developed compared to other dimensions, even though the concept of participation was the focal point in the revision process (Pfeiffer 2000; Hurst 2003).

Box 3: Definition of Dimensions in ICF

Body Functions are the physiological or psychological functions of body systems.

Body Structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function or structure such as a significant deviation or loss.

Activity is the performance of a task or action by an individual.

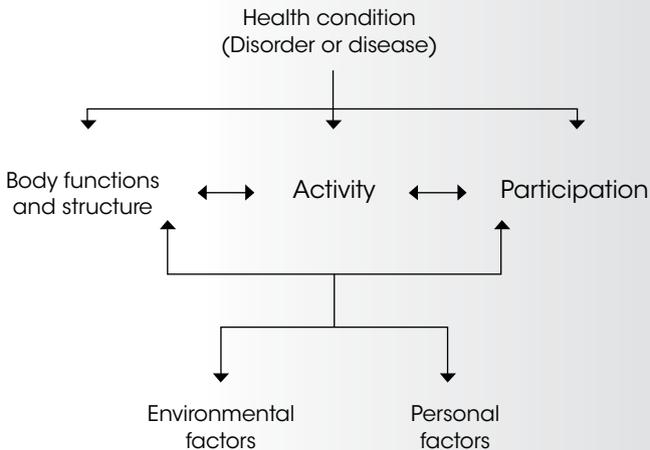
Activity Limitations are difficulties an individual may have in the performance of activities.

Participation is an individual's involvement in life situations in relation to Health Conditions, Body Functions and Structure, Activities, and Contextual factors.

Participation Restrictions are problems an individual may have in the manner or extent of involvement in life situations.

Source: (WHO 2002b)

Figure 2: Interactions between the Dimensions of ICF



Source: (WHO 2002b)

○ **Differentia Model of Disability**

The term “Differentia Model of disability” is not used as a specific identifiable model in disability discourse, but was developed by its proponents to categorise several models which shared some common elements. Both Social Model and Differentia Model criticised the Medical Model’s view of disability. However, the Differentia Model of disability also points out the limitations of the Social Model.

One limitation is that although it is an important aspect even in the Differentia Model, the Social Model focuses solely on the concepts of segregation and oppression. In addition, it treats disabled people as a homogeneous group, oppressed in terms of social relations and fails to reflect the diversity of experiences or perceptions of each individual with impairments. This includes experiences of impairments that may not necessarily be related to segregation or oppression.

As noted above, another limitation is that the Social Model focuses on the dichotomy between disabled people as oppressed and segregated, and non-disabled people as oppressors, as if the two are distinctive. The Differentia Model, therefore, emphasises the analysis of the experiences of each individual, interactions of people and discourse.

The above comments summarise the perspective of a number of different models. Different names are used in similar concepts by different researchers which creates a great deal of confusion. Further complicating the issue is the fact that the differences between each model are

not clear and some are combined and taken as a single model of disability by some researchers. In order to clarify the key differences between these views making up the Differentia Model, the sub-models are re-categorised into five models and summarised in the following section.

1. Social Model of Impairments

The Social Model of impairments viewed the experience of “impairments” as a largely negative experience. This is an important factor in understanding the lives and sense of identity of disabled people as well as disability in terms of social oppression. However, this element is neglected in the Social Model of Disability (Houston 2004). This model does not deny the importance of understanding disability in terms of segregation and oppression, but criticises its understanding of it as the main principle in this perspective (Morris 1992). Therefore, disability can be analysed holistically by applying both the principles of the Social Model of Disability and the Social Model of impairments together. In this way it can adequately reflect both the discriminative aspect of disability and the experience of impairments, the differences, or being different in society (Abberley 1997a).

The Synthesised Model and Social Model of impairments appear similar in terms of giving equal attention to both disability and impairments. However, impairments are viewed mostly from the physical and functional aspect in the Synthesised Model, but the aspect of its experience is given much focus in the Social Model of impairments. In contrast, the causal linkage between impairments and disability is still strong in Synthesised Model as it is inherited

from the Medical Model, while impairments and disabilities are treated relatively separately in the Social Model of impairments.

However, experiences of impairments, such as pain and functional limitations, are often taken as negative experiences in this model. This view is similar to the position of the Medical Model, and differs from the viewing impairment as a potentially positive experience as claimed by the Affirmation Model of disability. Therefore, by analysing impairments using this model attention is often drawn to the negative experiences of being disabled, and thereby re-emphasise the notion that being disabled is a tragedy and is an individual matter to be solved by dealing with individuals rather than society. This is criticised as a limitation of the Medical Model by proponents of the Social Model of Disability.

2. Culture Model of Disability

Culture Model of disability identifies certain groups of people as a cultural minority who shared the same culture and experience (such as communicating through the use of sign language), rather than as “abnormal” individuals as perceived in the Medical Model, or as oppressed people in the Social Model (Lane 1995; Kimura 2000). Based on this understanding, their lives and experiences are analysed as a cultural minority in society. Although physical and functional differences, or impairments, are taken as differences and as one of the reasons that a unique culture is developed, they are not considered as a critical factor in distinguishing people. Differences between this minority group and the majority are not based on

physical differences but cultural differences. For instance, Andersson, the President of the World Federation of the Deaf (WFD) stated that they are not disabled people but the Deaf. Therefore, using such terms as 'disabled people' to refer to the Deaf people is not appropriate in this model.

I believe that Deaf people in most countries will eventually regard themselves as a linguistic minority instead of a disability group. (Andersson 1994: 10)

In this model, identifying these people as a unique cultural group can be positive, in contrast to a negative identity such as "abnormal" in the Medical Model and as "oppressed" in the Social Model. While this view of disability has been mainly developed by the Deaf community, its applicability to other groups of disabled people, e.g., people with visual or physical impairments, has been studied and with no consensus as yet.

In this model, differences or heterogeneity is emphasised rather than homogeneity or "sameness", which is emphasised both in the Medical and Social Model. Therefore, even the concepts of integration or inclusion, which have been accepted as an ideal condition in both the Medical and Social Model, are challenged. Supporters of the Culture Model maintain that integration may coerce entry of the minority into majority culture, which may lead to cultural invasion of the minority. They propose co-existence as a minority group, with equal opportunity. Therefore, the main issue in this model is coercive integration and cultural invasion by the majority, and its aim is to maintain their own culture.

The Deaf are, however, different from other disability groups. Other organisations call for Inclusion and Mainstreaming in almost every aspect of life. While not condemning these objectives out of hand, the WFD seeks to keep a cautious distance (IDF 1999: 134).

This model contributes to the development of a positive identity of disabled people, and provides critical awareness relating to the notion of inclusion. However, a major limitation of this model is the incapability to reflect and understand functional difficulty and problems of individuals in daily living, which may have occurred due to the interaction between impairments and the social conditions. This is due to the notion that neglected physical and functional differences (impairments), as they deny being disabled, i.e., denying having physical and functional difficulties. Hence, this view may not be acceptable for disabled people who cannot ignore his or her physical and functional differences.

3. Affirmation Model of Disability

The Affirmation Model of disability views physical and functional differences positively, which had been viewed negatively in both the Medical and Social Model or ignored in the Culture Model (French 1997; Gilson and Depoy 2000; Swain and French 2000). Hence it perceives disabled people as positive beings who have positive and unique differences. This view made it possible to deal with issues of segregation or oppression without resorting to negative identities, by seeing segregation due to the lack of understanding of the positive uniqueness of disabled individuals.

Although Deaf people dismissed hearing impairments as a minor physical difference, for people with severe disabilities or intellectual disabilities, these profound differences cannot be ignored. In fact, they are one of the main factors of identity. However, by identifying their differences as positive uniqueness, they developed positive identity of themselves. Statements such as “impairments/disability is my (positive) identity” are based on this notion.

In this model, physical and functional differences are no longer imperfections to be corrected, but beauty or excellence to be embraced. Based on this understanding, this model views the “problem” lying with society, which does not value these differences positively and discriminates against these people by devaluing their beauty. Although it is similar to the Social Model in defining social exclusion and discrimination as problems, this model identified disabled people as both talented and oppressed.

In contrast, the Social Model identified disabled people as solely oppressed and this negative self-image paves the way to an understanding of society from a perspective of a dichotomy as either oppressor or oppressed. In contrast to the Culture Model where heterogeneity is attributed to a group of people, e.g., Deaf people, heterogeneity in this model is attributed to individuals. That is based on the notion that “everyone is different” and differences must be appreciated, a similar philosophy shared by the next two models. However, this model shares similar limitations as those of the Culture Model of disability. Practical difficulties due to physical differences can be neutralised because this model views such differences as positive rather than potential limitations or lack of capacity in daily life.

4. Inclusion Model of Disability

The term "Inclusion Model of disability" is developed to refer to the concept discussed in the IL Model of disability by Pfeiffer and the Social Model of Disability in the United States by Albrecht. The Inclusion Model of disability was developed using the polytomic view which distinguishes people, i.e., "everyone is different", in contrast to a dichotomous view, i.e. 'disabled people' and 'non-disabled people.' Examples of a dichotomous view include "normal – abnormal" in the Medical Model, "oppressor – oppressed" in the Social Model, and "majority – minority" in the Culture Model.

Although the Inclusion Model shares a similar polytomic view with the Affirmation Model and the Post-Modern Model, this model is different because it does not necessarily view differences positively. It often views differences as functional limitation. It is also different than the Post-Modern Model because differences are taken as physical differences and not solely as discourse.

In contrast to the Medical Model and Synthesised Model, which aims to integrate disabled people into society by mainly changing individuals (although it may include some changes in society), this model prioritises changing society. It aims to make society more inclusive; to fit society to every individual, rather than changing individuals. Although the Social Model proposes similar changes in society, its focus is given to institutions based on the perception of disabled people as a homogenous group.

In the Inclusion Model, differences in each individual were the main concern and priority is given to practical

interventions to deal with various needs and requirements of individuals to realise equality and inclusion, in addition to institutional interventions. By focusing on the differences of individuals and actual needs resulting from these differences, this model puts disability side by side with other differences, e.g., gender and ethnicity, and gives equal attention to these differences. I.e., disability is no longer a primary distinction but one of several factors to consider individuals' different needs.

The polytomic view of this model has both potentials and limitations. It dismantled the barriers posed by the dichotomous view. Therefore, the terms "normal and abnormal" are no longer categories of people. Hence, the term "normal" person is eliminated. This also promotes cooperation with other people who are also excluded due to differences and who are denied equal opportunities. However, by eliminating a more familiar social identity such as "oppressed or excluded," efforts by such a movement or a group demanding particular interventions might be weakened.

5. Post-Modern Model of Disability

The Post-modern Model of disability, or Post-structuralist Model of disability; deconstruction model of disability, was developed based on the philosophy of post-modernism which challenged the notion of objectivity and emphasised discourse (Ingstad and Whyte 1995; Corker and Shakespeare 2002). Therefore, disability is no longer considered as a definitive physical condition, but a condition developed and defined by social norms and perceptions of people (Devlieger 1995). For instance, being

blind is a condition where a person cannot see, but it is dependent on the social norms and discourse to identify it as a disability (Hughes 1999).

This model points out the importance of understanding people's perception and social norms with regard to both disability and disabled people. This model also has a polytomic view and opposes the homogenous view of grouping disabled people. As a result, this enables the analysis of power relation and inequality within groups of disabled people, e.g. inequality of power between: people with mild and severe impairments; male and female with impairments; rich and poor disabled people. However, the denial of an objective view of disability may raise difficulties in addressing impairments and practical day to day needs due to physical and functional differences.

In conclusion, the Differentia Model critically viewed the dichotomous and homogenous understanding of disability and disabled people, and allowed the polytomic view to understand individuals and the different experiences and thoughts among disabled people.

○ **Family Model of Disability**

The Family Model of disability claims that disabled people are not the only ones affected by disability, but family members as well. It argues that although their experience of disability is in a different form, it should be recognised and addressed as disability, since disability is a larger concept than merely physical and functional issues but social issues as well. This expanded view of disability incorporates a wider range of experiences of different but

key stakeholders in relation to disability. Although the term “Family Model of disability” has not been accepted as an established model of disability, the concept has been discussed in various studies (Kanameda 1999; Ferguson 2001; Brett 2002).

The Family Model is based on the understanding that each member of the family also experiences different kinds of impact, which are caused by the prevailing social norms and the inadequate support disabled people and their families receive from society. If disability is no longer an issue of body function itself, but issues of inequality, then experiences of family members should be taken as part of disability issues. However, this model is a complementary model not an alternative to the Social Model of Disability which provides an analytical view of the experiences of disabled individuals. This model expands the scope of primary stakeholders in disability from the exclusive domain of disabled people to incorporate both disabled people and their families by recognising the different types of experience of disability. This model does not imply that family is a unit of analysis of disability, but claims the existence of two (or more) different primary stakeholders who experienced different types of problems in relation to disability or as disability. Brett (2002: 832) lamented that parents felt that both their child and themselves were labelled as disabled by society, and consequently found themselves in a situation constrained by societal and environmental boundaries.

This model highlights the notion that each of the disabled person’s family members face various restrictions and burdens due to the lack of support by society. Their

experience of disability overlaps to some extent with the experiences of disabled individuals; however it is not necessarily the same. For instance, disabled individuals may face the need for independence as their problem but independence itself is not an issue for the family. The experience of burden of care and on-going support are more often the disability experience of the family. Since “disability” in this context is not similar, different disabilities should be distinguished and analysed differently.

As the Social Model reveals the importance of reflecting the disabled person’s own views and experiences in order to understand problems faced by disabled people, it is also important to reflect the family’s own views in order to understand their own experience of disability. Both views need to be taken in order to achieve a holistic understanding of disability. It is important to understand the differences of experience, perception and interests of these two stakeholders. Parents, for example, are often identified as barriers to independent living of disabled people in the Social Model perspective. However, the model failed to acknowledge the perceptions and experiences of parents themselves. Incorporating the Family Model of disability with the Social Model helps to overcome this limitation.

There are three potential limitations to bear in mind when applying the Family Model. Firstly, we should not assume family as a unit of analysis of disability. Disabled individuals and family are distinctive stakeholders of different type of disabilities, although they may share similar problems to some extent. Secondly, we should not assume that all experiences of family are negative. Most members of families have both positive and negative experiences.

Their negative experiences, however, are largely due to a lack of social support or prevailing negative social norms. As described above, the third potential limitation is that this model is only capable of providing an understanding of the experience of family members. If other complementary models focusing on the disabled person are not taken into account, then an analysis is largely limited to aspects of care and burden of care.

In this section, an attempt was made to explore various models of disability. There is a common understanding that it is no longer valid to understand disability solely from the perspective of the physical or intellectual functioning, i.e. the Medical Model of Disability. Further this analysis suggests that the greatest common origin of the meaning of disability can be explained as the outcome of the interaction between a person with impairment and the environmental and societal attitudes (Yeo 2002). Therefore, although the Social Model of Disability also has several limitations, it still provides fundamental framework to raise awareness disability as social issues.

■ 2. Participation

Since the slogan, "realisation of full participation and equality of all disabled people" was adopted as an ultimate goal of the International Year of Disabled People by the UN, the concept of participation has been gradually developed into a conceptual framework used to analyse and deepen the understanding of the disability experience. In the field of disability, the concept of participation is often used interchangeably with the concept of equal opportunity and social inclusion. For instance, such interchangeable

explanations are found in the two key documents, the World Programme of Action Concerning Disabled Persons (WPA) and the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (Standard Rules) (UN 1982, 1993).

Adaptation of the concept of participation as an analytical framework was accelerated by the implementation of the new classification of disability of the WHO, i.e., the ICF. It adopted participation and participation restriction as concepts with which to understand social aspects of disability in addition to the traditional concepts of body function and structure and activity limitation. Participation also took central position as an alternative concept and approach in the field of social development. Participatory development and the related concepts of empowerment, decentralisation and participatory approaches has become one of the crucial notions in social development.

In general, definitions of participation refer to the action and rights for individuals to relate with society. Definition of participation for the International Year of the Disabled Persons (IYDP) gives relatively comprehensive explanation as follows:

The right of persons with disabilities to take part fully in the life and development of their societies, enjoy living conditions equally to those of other citizens, and have an equal share in improved conditions resulting from socio-economic development (UN 2000a).

While realisation of both full participation of and equal opportunity for all disabled people was accepted as an overarching goal in the disability field, participation is the dominant concept. This is seen in the fact that participation and recognising the obstacles to participation is the central platform of the disability movement. The concept is also fundamental in the Social Model of Disability (UPIAS 1975; Barnes 1999; Drake 1999). It is reflected in international policies, such as UN Convention on the Rights of Disabled Persons, the World Programme of Action Concerning Disabled Persons (WPA) and Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (Standard Rules).

“Full participation” is defined in the statement issued in the IYDP as mentioned above. In the WPA, “Full participation” is adopted as an ultimate goal, prior to prevention and rehabilitation (paragraph 1). These statements acknowledge that full participation within the basic units of society – family, social groups and community – is the essence of the human experience.

As the definition of participation used in the IYDP implies, participation can be viewed from two different perspectives, as a result and as a process. In other words, participation has the potential to be an outcome or result of a disabled person being in an inclusive society. It can also be a means or process of building such a society. While participation is a goal, the importance of the latter perspective on participation is also a central issue in current discussions.

The Regional Inter-agency Committee for Asia and the Pacific (1997) which consists of ten UN agencies and

sixteen NGOs including DPI, stated that the participation of disabled people at all levels and in all stages is important, especially in the decision making process. Their participation as role models as a means of changing prevailing negative images of disabled people was emphasised (Hurst 1998). Such negative attitudes, restrict the participation of disabled people as contributors, and exclude them from decision-making processes.

Finkelstein (1998a) argued that it is important for disabled people to participate in the development of an alternative culture leading to a better society. He emphasised that the 'aspirations' of disabled people is the fundamental basis for action to deal with disablements, not the 'needs' that are assessed by rehabilitation professionals. He further states that professionals cannot assess their aspirations because only disabled people themselves are able to identify and realise their own aspirations. Hence without the participation of disabled people, appropriate actions cannot be developed.

Werner (1994b) highlighted the importance of the participation of disabled people from a more practical point of view, by rating 'being a disabled person' as a positive qualification to be a contributor to disability related programme such as Community Based Rehabilitation (CBR), not as a negative factor. He identified five reasons for this. By the fact of their being disabled they can: 1) be more sensitive to the needs and feelings of other disabled people, hence have a stronger commitment; 2) give disabled people the opportunity to evaluate their own needs; 3) meet the real needs of disabled people; and most importantly, 4) become a role model for society thereby

making CBR an ennoblement or empowerment process; thus 5) it provides a liberating point of view to the disabled people, and it changes rehabilitation professionals whose attitudes are the hardest to change.

In the social development discourse, 'participation' became a critical concept in the 1990s. However, what went under the name of participation took multiple forms, and served different interests, i.e., concepts were highly contested (White and Tiongco 1997: 107). As a consequence, approaches to and outcomes of participatory development projects are varied, and it is important to clarify the different understandings of participation.

There are several concepts of participation that seem to share a similar feature in that they distinguish the modes of participation by analysing whose interests are served; i.e. those of the implementers or of the people served (Cornwall and Fleming 1995). If the focus is on the implementers, then participation is bound to be discussed in terms of efficiency and sustainability. If the focus is on the people served, then it is more likely that the discourse will be oriented toward empowerment.

Pretty (1995) argued that two overlapping schools of thought and practice of participation have evolved. One views participation as a means of increasing efficiency, i.e. co-opting people to support a project in terms of manpower. The other sees participation as a fundamental right, in which the main aim is to initiate mobilisation for collective action, empowerment, and institution building.

In reality, participation is more often used for co-option, i.e. people are asked to participate in an operation that may be of no interest to them, in the name of participation. Similarly, White and Tiongco (1997) and Chambers (1997) explained that participation should be an empowerment process but it is often utilised for other goals such as cost-effectiveness.

Chambers divided it into three categories; a cosmetic label to make whatever appeared good; a co-opting practice to reduce costs; and an empowering process which enabled local people to do their own analysis to take command, to gain in confidence, and to make their own decisions (Chambers 1994). White and Tiongco elaborated it into four types, while Pretty categorised them into seven types (Pretty 1995; White and Tiongco 1997). These three typologies are useful analytical frameworks, and the major types of participation may be classified as in Table 3: just a name; as a means for other ends; and as a goal of empowerment.

Participation and empowerment are two sides of the same coin, and empowerment is seen as the ideal mode of participation. In the next section, the various forms of empowerment will be addressed as has been done with the concept of participation in this section.

Table 3: Typology of Participation

	Chambers	White & Tiongco	Pretty
As a name	Cosmetic label	Nominal	Manipulative
As means for other ends	Co-opting practice	Instrumental Representative	Passive By consultation For material incentives Functional Interactive
As a goal of empowerment	Empowering process	Transformative	Self-mobilisation

Source: (Chambers 1994: 30; Pretty 1995: 1252; White and Tiongco 1997: 106-9)

■ 3. Empowerment

The notion of ‘empowerment’ was introduced in the 1960s as the “idea that some can act on others to give them power or enable them to realise their own potential” (Nelson and Wright 1997b: 7). It was also described as “the desirable state of affairs in which individuals have choice and control in everyday aspects of their lives: their labour, reproduction, access to resources, etc” (Hewitt and Smyth 1992: 91). Today, concepts of empowerment are highly contested (White and Tiongco 1997: 107). The definition varies depending on how power is defined. The crucial question that arises from the definitions is who can empower disabled people in the community and how. Three models of power are used to analyse different aspects of empowerment. These are: 1) human development model, 2) political conflict model (which has three different viewpoints), and 3) decentred model. Each is based on different metaphors, and conveys very different ideas about ‘what power is and how it works’.

○ **Human Development Model**

This model uses a metaphor of human development and suggests that power can grow infinitely just as human abilities do. In this model, power is seen as the 'power to'. Rowland (1995: 103; 1997: 110-28) discusses three dimensions of empowerment in this model: personal, close relationships, and collective. The first dimension, 'personal' refers to the development of the sense of self, confidence and capacity. The second, 'close relationship', is the development of one's abilities to negotiate and influence decision-making. The third, 'collective', is to work together to achieve a more extensive impact than each could have had alone. In this way it views the growth of one person as not necessarily negatively affecting another and power can be seen as a 'positive sum' (Nelson and Wright 1997a: 8).

○ **Political Conflict Model**

This model consists of three sub-models, but all of them view power as political conflict. Power is viewed as coercive and centred in institutions such as the state; the power relation is seen as a 'zero-sum relation', i.e. if one gains power, the other loses it.

A one-dimensional view of power is based on the pluralist theory, and was developed by Dahl and Polsby as a critique to the elitist theory of power, i.e. there is no single elite in a given society, but power is distributed among different groups (Lukes 1993: 11-5). Power is seen in the actual decision-making process in the political arena as observable conflict, and peoples' interests are seen as

policy preferences which are expressed through political participation in the formal political system. Therefore, empowerment is seen as allowing the beneficiaries or their representatives to win in the political arena.

A two-dimensional view of power was developed by Bacharach and Baratz as a critique to the pluralist theory of power, which overestimates the power in the political decision-making process (Lukes 1993: 16-20). For instance, equal rights of minorities or environmental issues may not be on the agenda because of restriction, coercion, media control, bribery or threats by 'powerful' people who may lose their advantage by putting these topics on the agenda in the decision-making process. Power is seen in both decision-making and non-decision-making, so conflict may not be overt but covert, and peoples' interests are seen as policy preferences or grievances. Persons or groups who create barriers to the public airing of policy conflict, i.e. agenda setting, have power. Empowerment, therefore, may mean to help beneficiaries to raise their issues in the political arena, i.e. put their issues on the agenda in decision-making process.

A three-dimensional view of power is developed by Marxists as a critique to the two-dimensional view of power (Lukes 1993). In contrast to one- and two-dimensional views of power which assume people are aware of their interests, and individuals exercise their power, the three-dimensional view of power conceives that people are unaware of their real interests, so power is seen as the interests of a particular class of people, not of individuals. Power may not be seen as observable conflict but latent conflict, and people can have power without conflict by

using their authority or manipulation to shape peoples' perception or false-consciousness of their understanding of reality, i.e. make people accept the present situation as unchangeable. Empowerment, therefore, takes approaches of conscientisation or awareness raising of real interests.

Freire argues that empowerment should be thought of in social class terms, and said "the question of social class empowerment...makes empowerment much more than an individual or psychological event. It points to a political process by the dominated classes who seek their own freedom from domination, a long historical process" (Freire and Shor 1987: 108-15). This view of empowerment is taken by numerous grassroots development organisations as a theoretical basis toward the liberation of oppressed people. However, the fundamental question still remains in this view: how the 'real interests' of people can be defined and by whom (Lukes 1993: 26).

○ Decentred Model

Foucault's view of power is different from the traditional views of power mentioned in the previous two models (Table 4). One fundamental difference is that he does not see power as a zero-sum relation, or win-lose relation. The second difference is that he challenges the notion of the sovereignty of a power – centred view of power. Hence, this model is called the decentred view of power (Nelson and Wright 1997b: 9-10). The notion of empowerment is seen as problematic in this model, since power is decentred and omnipresent. Hence, there is no ruling class or fixed distinction between powerful and powerless people, but power flows. This decentred view of power undermines the

Table 4: Decentred View of Power by Foucault

Foucault's view	Traditional view
(primarily) positive	negative
productive	restrictive
exercised	possessed
omnipresent	localised
set of relation	commodity
from bottom to top	from top to bottom

Source: (DuBois 1991: 5)

theoretical basis of emancipatory movements, including Freire, and even suggests that revolution may not challenge power relations.

■ 4. Social Exclusion

The idea of social exclusion first appeared in 'Les Exclus: un francais sur dix' written by Rene Lenoir in 1974. The concept of social exclusion is now extensively used in both social development and disability discourse to describe social disadvantage. However, the concept of social exclusion is still ambiguous, complex, expansive and contested, and can be interpreted and defined in different ways (Silver 1995).

Until recently, a Biomedical Model focusing largely on impairments of disabled individuals was prevalent, a model

which ignored the role of society. Because many disabled people view their exclusion from society as a 'disability', a framework which highlights the interaction of disabled people within society is needed.

The disability movement sees inclusion as an ideal goal while exclusion from society, especially in the form of institutionalisation or segregation, is seen as detrimental. This goal has been popularised in theory in the development of Social Model of Disability and in practice in the IL movement. As noted above, it has been embraced not only by disabled peoples' organisations, such as DPI and IL, but also reflected in two key international policies on disability, i.e. WPA and Standard Rules.

In both these policies, while both education and employment are emphasised, exclusion from every aspect of life, including cultural and social life and social security are recognised as barriers. Another factor in exclusion is human interaction, e.g. attitudes, behaviour or prejudice and discrimination (WPA, paragraph 72). The strongest mode of exclusion recognised in the documents is institutionalisation or confinement of disabled people in institutional care (paragraph 75).

The fundamental advantage of the concept of social exclusion as a framework of analysis, then, is that it focuses on the relationship between disabled individuals and society, or excluding institutions and not merely on disabled individuals. Based on this, the social exclusion concept sheds light on social interaction, including attitudinal aspects, and the segregated nature of lives of disabled people. Despite the strengths of the concept there has

been several critique of its use as a framework of analysis on disability (particularly from the Deaf community) which will be addressed in the next section.

In the social development discourse, the concept of social exclusion rapidly gained recognition after the World Summit of Social Development, and this has led many development agencies to adopt it as a fundamental component in development (De Alcántara 1995; UN 1995; Porter 2000). UNDP also considers social exclusion to be one of the keys to defining and alleviating poverty (UNDP 1997). A speech by the President of the World Bank was centred on issues closely related to inclusive development, apparently in recognition of the importance of socially inclusive development as one of the four key lessons learnt during the last fifty years of experience in development (World Bank 2000: 1). The concept of social exclusion rapidly gained prominence in development, because previous influential development paradigms, namely, trickle down theory, the neo-liberal counterrevolution, and the new poverty agenda, could not deal with the question of participation sufficiently (Clert 1999).

○ **Critique of the Concept of Social Exclusion**

Two major critiques are raised here, although both are closely related. They are based on the dualistic nature of the concept of social exclusion, i.e. categorising people as 'included' or 'excluded'. This way of understanding disability issues as binary opposites cannot fully explain the complexity of the experiences of disabled people and how these experiences are controlled or regulated by the dominant culture (Corker 1998).

The first critique is that the social exclusion concept does not adequately describe situations of unequal inclusion, and more specifically, it does not distinguish between integration and inclusion. For example, integrated classes for the Deaf and hearing children can be viewed as an inclusive goal. However, if there is no appropriate support for the Deaf children, their conditions for learning will not be the same as their hearing peers and perhaps worse off than if they were in a separate educational system. It is not inclusion if there are no equal opportunities and conditions.

A second critique is that the concept tends to be “all or none”; that it completely supports inclusion, and sees exclusion as an absolute negative. On the one hand, positive exclusion can be an empowering process. on the other hand, forced integration can be a dis-empowering process. The following example shows some of the challenges with the concept of inclusion.

One approach that has been used in education for the past 30 years is integrated education. However, the aim of integrated education was to ‘integrate’ disabled children into mainstream education based on the dichotomous notion of disabled and non-disabled children. Integrated education often forced the Deaf children to communicate orally and prohibited the use of sign language. This practical application of the idea of integration has been criticised because it still maintains its discriminatory nature in its concepts by viewing disabled people as a minority to be integrated by ‘normalising’ them.

In response to these critiques, the concept of inclusion was developed. In contrast to the dichotomous notion

of integration, the concept of inclusion is based on a pluralistic understanding of differences, not a dualistic way. There is no one to be integrated since society is for all. The difference between the concept of integration and inclusion are explained as follows in relation to the Deaf.

Inclusion is: "the process of social and/or educational integration where everyone, whether disabled or not, deaf or hearing, is able to participate, to engage in self-expression and to determine collectively norms, codes of behaviour and the necessity for change". Integration on the other hand is "the process of educating disabled and deaf children alongside non-disabled and non-deaf children in mainstream schools according to hearing and non-disabled norms and codes of behaviour". The emphasis is therefore on Deaf and disabled children 'fitting' into a preconceived and often experientially irrelevant framework (Corker 1998: 146).

The experience of the Deaf people illustrates the futility of seeing exclusion and inclusion in an absolute way. In education, the Deaf people were banned from using sign language until recently in many countries. The rationale was that the use of sign language would hinder the acquisition of the spoken language and, hence, obstruct the Deaf people from being integrated in societies. However, this suppression of the sign language threatened both the maintenance of the Deaf culture and the self-esteem of the Deaf individuals. In fact the Deaf community sees denial of the right to use sign language as a serious problem and the forced integration of Deaf children into the hearing schools as a persecution of the

Deaf culture (Nagase 1995: 51; IDF 1999: 133). Segregated or separate approaches are preferred by the Deaf community as an empowerment process, rather than an integrated one. The right to have separate education for the Deaf was acknowledged on an international level in the Salamanca statement that aims to promote inclusive education (UNESCO 1994).

In summary, both integration and inclusion are approaches to preventing exclusion. However, there are different levels of equality among those who are 'included'. In addition, there are situations where being included is not absolutely positive and where being excluded is not negative and may even lead to empowerment. Therefore, a social exclusion concept which merely distinguishes the 'excluded' and 'included' may not shed sufficient light on these problems.

○ **Meaning of Social Exclusion and Inclusion**

Meanings of social exclusion are embedded in conflicting social science paradigms and political ideologies. As Silver distinguishes three paradigms of social exclusion, namely solidarity, specialisation and monopoly paradigms; it could be problematic to have one fixed definition of social exclusion (Appendix II-1). This difficulty, however, provides a theoretical opportunity where multiple meanings of the term serve as a window through which one may view issues from different perspectives (Silver 1995:60).

Social exclusion is conceptualised in two ways, as a property of individuals and as an attribute of society. In the former, the focus is on the situations of disadvantaged

people based on the analysis of socio-economic characteristics of income-poor people. In the latter, focus is placed on institutions and rules, which enables and constrains human interaction (IILS 1996: 11-2; Clert 1999). Social exclusion can also be referred to the processes which bring about a lack of citizenship, whether economic, political or social. From this view, social exclusion reduces equality of opportunity and access to resources, including social and material wealth (Rogaly et al. 1999: 9-10). It is also important to define social exclusion as a lack of control over one's own life (Ginneken 1998). For instance, many people say that disabled people in developing countries are more included in society than developing countries, since disabled people are more visible than some developed countries. However, this does not mean that they are included in society equally and have power to control their own lives. They may be merely integrated in a society with unequal status.

There are, however, common features of understanding social exclusion: 1) multidimensionality, 2) shed light on the process and mechanisms, 3) institutions and agencies are seen as actors of exclusion, and 4) attribute society, as well as individual (Gore 1995; IILS 1996: 14-7; De Haan 1998a: 11-3; Clert 1999: 180).

Although there are some commonalities, strategies to combat social exclusion vary based on what they are aiming at (Silver 1995: 77). For instance, in the traditional notion of the solidarity approach, exclusion means a deviance or anomie, which both threatens and reinforces social cohesion. Therefore, the inverse of exclusion is integration and the process of attaining it, or insertion. In a

Durkheimian sense, this implies assimilation to the dominant culture. This shares the same notion with the traditional understanding of disabled people as abnormal people to be normalised. In this sense, integration does not mean social change but to change the excluded individuals, or to provide some space in the current society.

However, this kind of integration is not seen as an ideal goal in other paradigms. United Nations Research Institute for Social Development (UNRISD) states that social integration is not how to increase integration per se, but how to promote a kind of integration which favours the creation of a more just and equitable society, i.e. social reform is required (United Nations Research Institute for Social Development 1994). On the other hand, although inclusion is often accepted as absolutely positive without questioning, it can in fact be a negative process as in the case of co-opting or imposition of uniformity. UNRISD summarised three possible results of integration as follows:

1. Inclusionary goal: This implies that integration gives equal opportunities and rights for all human beings;
2. Negative connotation: Integration becomes a co-option process, i.e. conjuring up the image of an unwanted imposition of uniformity;
3. Neither positive nor negative state: It is simply a way of describing the established patterns of human relations in any given society (United Nations Research Institute for Social Development 1994).

The majority of criticisms raised are with regard to the dualistic notion of the social exclusion concept. Although its dualistic features have successfully paid attention to the

unequal institutions and relations between the “included” and the “excluded,” an over-emphasis on the dualistic structures tend to view the relationship as static or fixed, and misses the fact that people are moving between the “included” and the “excluded” in different spheres and time (Jackson 1999; Porter 2000: 77). For instance, an ethnic minority male may be excluded from the mainstream labour market, but within his own community, he may be a leader and “included” in the local decision-making process, whereas female members of the community maybe excluded from such processes. In the next section, six limitations and implications of the social exclusion concept are summarised.

The first is the tendency to identify a new group as an excluded group, or stigmatising people as outsiders because of the dualistic notion to distinguish people into two groups (De Haan and Maxwell 1998; Jackson 1999). The second limitation is that this dualistic notion also ignores and undermines an understanding of alternative spaces and counter-culture, e.g. feminism or the Deaf culture, in which segregated people have found a space in which they can develop their own understanding of the world and their place within it. This alternative space gives resistance to the mainstream and presents an alternative viewpoint, counter-culture or value system to create a more multi-cultural and just society. In other words, inclusive policy could encourage co-opting practices to prevent the birth of counter-cultures (Morris 1997; Corker 1998; Jackson 1999).

The third point relates to the lack of ability to deal with unequal inclusion. The fourth point is that the social exclusion

framework focuses too much on structural process and it risks missing actual relationships. This undermines the element of negotiation, struggle, and resistance to power (Porter 2000: 79). The fifth limitation is the importation of the social exclusion concept from Western social policies. It is based on particular historical processes of industrialisation and formal productive employment, and it may differ from the context in the South (De Haan and Maxwell 1998; Jackson 1999). The last limitation is the lack of measurable indicators (De Haan 1998b). It is always important to ask inclusion in what and on what terms, and to clarify how inclusion and exclusion are defined and by whom, rather than merely to identify who is excluded, since the concept of social exclusion is context dependent (UNRISD 1994; Jackson 1999; Porter 2000).

■ 5. Capability Approach

○ Introduction

The Capability Approach provides a comprehensive bird's-eye view on the issues and situations surrounding disabled people and their society. It integrates issues around both disability and other social issues which have been dissociated previously.

The Capability Approach, which was first proposed by Amartya Sen, suggests that the evaluation of personal well-being and social arrangements should be based on what people are able to be and do (Sen 1992, 1999). It thus shifts the evaluation away from utility, resources and income to the Functionings and the Capabilities. Functionings refer to people's beings and doings, like being healthy, being

part of a social network, being sheltered, and so forth. Functionings can be specified at the realised level and Capabilities at the potential level.

The Capability Approach advocates that when we conceptualise or evaluate poverty levels, inequality, social policy, efficiency, or development, we should do this in the scope of Functionings and Capabilities. The approach focuses on people's substantive freedoms or real opportunities by looking at their Capabilities. Policies should concentrate on expanding people's Capabilities.

Sen himself has deliberately formulated the Capability Approach as a broad framework of thought, implying that further specifications and applications should always be context-dependent. The Capability Approach has been taken up by scholars in a wide range of fields. It has been taken as one of the important frameworks of thought in the field of social development due to its potentials as an analytical framework to understand well-being and quality of life (QOL) of people comprehensively, as it is taken as a basis of the UNDP's Human Development Index (HDI) (Anand and Sen; UNDP 1997; Robeyns 2004). Martha Nussbaum has developed her own version of the Capability Approach to argue for minimal levels of Capabilities as a constitutional guarantee. By the same token, potentials and limitations of this approach have been discussed in the field of disability (Iwasaki 1997b, 1998; Burchardt 2004).

For a long time, issues around disability, e.g., impairments or equality of opportunities, and issues around social development, e.g., poverty, have been analysed within different frameworks and have neither been linked to each

other nor taken in a holistic picture, although some attempts were made to develop a framework to reflect both issues in one framework by finding a causal linkage of these two issues (SIDA 1995). However, having identified disability as a crosscutting issue rather than as an isolated issue, the necessity for a comprehensive framework to reflect issues and factors in both dimensions in one large map of analysis has been raised. Therefore, discussions of the potentials of the Capability Approach as a comprehensive framework to analyse disability in the context of social development have gradually emerged especially in recent years (Iwasaki 1997b, 1997a, 1998; Lang and Seddon 1999; Seddon et al. 2001; Baylies 2002; Manderson 2002; Welch 2002, 2003, 2004; Kuno and Seddon 2003; Mitra 2003; Nussbaum 2003; Terzi 2003; Bakhshi et al. 2004; Demuijnck and Clainche 2004; Hamzetta 2004; Zaidi and Burchardt 2004).

Although Sen refers to the conditions of disability as an example to explain the advantage of the Capability Approach to grasp “practical opportunity” of individuals rather than superficial opportunity, Sen himself has not dealt with the Capability Approach to disability until recently (Mitra 2003: 14). However, in a recent speech at the World Bank, he referred to the Capability Approach in reference to disability and concluded that it had potentials even for an analysis of disability (Erb and Harriss-White 2001; Sen 2004).

One of the key reasons why the Capability Approach has been considered as a framework for disability in the above references is that it reflects a wide variety of factors within one framework using the concept of Capabilities and Functionings. For instance, Mitra stated as follows:

This framework (Capability Approach) improves our understanding of disability by allowing us to analyse how disability results from the interaction between the personal characteristics, the resources and the environment (physical, social, economic, political) of the individual as well as the person's psychic states (bracket added by author) (Mitra 2003: 2).

Such characteristics are even evaluated as an alternative framework to overcome dualistic discussion in the field of disability (Welch 2002). For instance, the ICF is also one of the comprehensive frameworks which attempted to analyse disability as a biopsychosocial issue, and took the concept of "participation" and "participation restriction" as a dimension to analyse social aspects of disability. However, ICF reflected only disability-related factors and do not and cannot reflect non-disability-related factors, such as gender, poverty, or ethnicity, which are equally important factors to understand the daily lives of people with disabilities, especially in developing countries (WHO 2002b).

○ **Key Concepts of the Capability Approach**

The Capability Approach is a broad normative framework for the analysis of individuals' well-being, which is primarily a mode of thinking about normative issues, hence – loosely defined – a paradigm (Robeyns 2003: 8). Sen believes that well-being and development should be discussed in terms of people's Capabilities to Functionings, that is, on their effective opportunities to undertake the actions and activities that they want to engage in, and be who they want to be.

Therefore, the core characteristic of the Capability Approach is its focus on peoples' ability to do and to be, that is, based on their Capabilities. This contrasts with philosophical approaches that concentrate on people's happiness or desire-fulfilment, or on theoretical and practical approaches that concentrate on income, expenditures, consumption or basic needs fulfilment. Sen argued that in social analysis, the focus should be on what people are able to do and be, on the quality of their life, and on removing obstacles in their lives so that they have more freedom to live the kind of life which they find valuable:

The Capability Approach to a person's advantage is concerned with evaluating it in terms of his or her actual ability to achieve various valuable Functionings as a part of living. The corresponding approach to social advantage - for aggregative appraisal as well as for the choice of institutions and policy - takes the set of individual Capabilities as constituting an indispensable and central part of the relevant informational base of such evaluation (Sen 1993: 30).

The major constituents of the Capability Approach are Functionings and Capabilities. Functionings are the "beings and doings" of a person, whereas a person's Capability is "the various combinations of Functionings that a person can achieve. Capability is thus a set of vectors of Functionings, reflecting the person's freedom to lead one type of life or another" (Sen 1992).

In Sen's approach, Capability does not constitute the presence of a physical or a mental ability; rather it is understood as practical opportunity.

Functioning is the actual achievement of the individual, what he or she actually achieves being or doing. Here, disability can be understood as a Capability or Functionings deprivation that result from the interaction of (i) an individual's personal characteristics (e.g., age, impairment) and (ii) his or her basket of available goods (assets and income) and (iii) the environment (social, economic, political and cultural) (Mitra 2003: 4).

A person's Functionings and her Capability are closely related but distinct.

A Functioning is an achievement, whereas a Capability is the ability to achieve. Functionings are, in a sense, more directly related to living conditions, since they are different aspects of living conditions. Capabilities, in contrast, are notions of freedom, in the positive sense: what real opportunities you have regarding the life you may lead (Sen 1987: 36).

The difference between Functionings and Capabilities can be clarified with an example. Sen's classical illustration showed the comparison of two persons, one who lived in conditions of famine and another on a hunger strike. Although both persons lacked the Functionings of being well-nourished, the freedom they have to avoid being hungry is crucially distinct. To be able to make this distinction, we need the concept of Capability, i.e. freedom, actual opportunity or the Functionings that a person *could* have achieved.

Another crucial distinction in the Capability Approach is the distinction between commodities and Functionings. By

this distinction, Capability can clearly be taken as a freedom and actual opportunities to transform commodities to Functionings, and conversion factors are identified: these are *personal factors/characteristics* (e.g. metabolism, physical condition, sex, reading skills, intelligence), and *social and environmental factors/characteristics* (e.g. public policies, social norms, discriminating practises, gender roles, societal hierarchies, climate, infrastructure, institutions, public goods). Take, for instance, a person with paralysis. Even though she has a wheelchair (commodity), if she does not know how to use it (personal factors), or if the roads are not accessible or community members hold negative attitudes about people with impairments (social and environmental factors), her Functionings of “mobility in the community” may not be achieved. Hence, to understand the Functionings a person can achieve, it is not enough to know the nature and quantity of the goods a person owns. Additional information is needed about the person and the circumstances in which he or she is living.

The Capability Approach does not consider the Functionings that a person has achieved as the ultimate normative measure. In principle, it is concerned with people’s real freedoms, that is, with their Capability to function, and not with one’s achieved Functionings levels. The Functionings of a person are the set of things that one is and does in life, whereas the Capability of that person is the alternative combination of Functionings that this person can achieve and from which one can choose. Capability is thus closely related to the idea of opportunity.

One of the strengths of the Capability Approach is that it can account for interpersonal variations, i.e. personal

or social and environmental factors. This is of central importance to Sen:

Investigations of equality – theoretical as well as practical – that proceed with the assumption of antecedent uniformity (including the presumption that ‘all men are created equal’) thus miss out on a major aspect of the problem. Human diversity is no secondary complication (to be ignored, or to be introduced ‘later on’); it is a fundamental aspect of our interest in equality (Sen 1992: xi).

This is particularly important in the analysis of well-being of disabled people because their personal factors are varied and it is very much influenced by social and environmental factors (Mitra 2003; Terzi 2003; Welch 2002, 2003, 2004). This aspect is one of the features that make it so relevant in the analysis of well-being of people in unequal conditions, e.g. women and minorities. Applied in the context of disabled people, it recognised disability as an issue of inequality rather than physical conditions. Sen used the conditions of disabled people as an example to explain the importance of using Capability to analyse well-being rather than commodity, because of the variety of influence of the personal, social and environmental conversion factors:

A person who has a disability may have a larger basket of primary goods and yet have less chance to lead a normal life (or to pursue her objectives) than an able-bodied person with a smaller basket of primary goods. Similarly, an older person or a person more prone to illness can be more disadvantaged in a generally accepted

sense even with a larger bundle of primary goods (Sen 1999: 74).

Welch (2002) examined the relevance of the Capability Approach to analyse disability in the context of social development by exploring the similarities of issues in disability, poverty and gender, and concluded that the Capability Approach can be a single comprehensive framework to examine these issues in one single framework.

When poverty is combined with inequality, regardless if it is based on gender, disability, or socio-economic status, the result is severe failure of Capabilities. Interestingly, poor and disabled people as well as women and girls traditionally lack opportunities, resources, and support to develop and promote their Capabilities. Thus, the application of a Capability Approach in addressing these areas seems appropriate and a necessary mechanism of intervention for the development of these groups (Welch 2002: 4).

Like other approaches, the Capability Approach also has limitations and debatable issues. Robeyns summarised them into the following four points: 1) the selection of Capabilities, that is, the question of what Capabilities constitute a list of relevant Capabilities; 2) the dispute around whether or not the Capability Approach is too individualistic; 3) the discussion about the critical or conservative nature of the Capability Approach, and related to that, the treatment of choice and power; and finally, 4) the question whether the Capability Approach will encourage paternalism and inappropriate policies (Robeyns 2003). These limitations

are discussed in relation to the context of disability in the following sections.

○ **Implications of the Capability Approach for Disability**

Using the Capability Approach, the situation of disabled people is pictured as a result of a combination of different factors. These factors include: 1) the nature of impairment and other personal characteristics, e.g., age and gender, 2) the resources available to the individual, and; 3) the social and environmental factors (Mitra 2003: 16).

The key difference of the Capability Approach from the ICF is that the Capability Approach reflects other personal characteristics rather than impairments in its analysis. In addition, it considers resources as an important factor resulting in the actual potential and opportunity of disabled people (Mitra 2003). Another key difference is that the Capability Approach aims at the analysis of the potentials of a person to realise a variety of Functionings or aspirations rather than actual achievement of the list of Functionings which is based on a preset list of expectations to perform by society (Mitra 2003: 20). In another words, Capability Approach is based on what individuals value doing and being as opposed to expectations foisted upon them by the society. This is the basic assumption in Sen's work and the reason that he is opposed to establishing a "standard" list of Capabilities. This is in contrast to Nussbaum's application of the approach in which she developed such a list of Capabilities.

The Capability Approach has potentials to be a comprehensive framework of thought on issues and conditions which relate to disability in the context of social

development by its provision of various useful implications. The Capability Approach makes it possible to understand and analyse issues and factors which have been dealt with differently within two different frameworks in disability and social development. The concepts of Functionings and Capabilities allow for a comprehensive understanding of the entire spectrum of life and daily living of people, although some other frameworks also attempt to grasp these issues in a holistic picture in forming causal linkages (SIDA 1995). Most importantly, these issues and factors are not considered independently in the framework, but transformed into one holistic concept of Functionings and Capabilities, which explain actual opportunities and freedom in life, hence, well-being and the quality of life of people.

Overall, the Capability Approach of disability is a holistic approach to disability that accounts for the importance of economic, personal and environmental and social factors in understanding Capability deprivation (Mitra 2003: 18).

Disabled people face conditions and issues not only in relation to disability, but also other issues just as other members of families and communities do. It may be that issues related directly to his or her disability may not necessarily be primary challenges for a disabled person. Other issues, such as poverty and discrimination due to ones' ethnicity or gender, may have a larger impact on that person. Regardless of impairments, people are not free from the culture and the institutions of their society, especially in developing countries where factors such as tribalism, poverty, and political restrictions are of greater influence.

For example, a scheduled caste disabled person may face greater barriers to finding employment because of his or her caste than because of the loss of one limb. Therefore, it is important to reflect on these various issues and factors which people face that influences ones' own living and life. Although ICF has been developed as a comprehensive framework to understand disability and life of disabled people, its comprehensiveness is only within the context of disability and cannot reflect other social and environmental factors and issues in its framework, as WHO itself admitted to as a limitation (Ustun 1998a; Ustun et al. 1998). The Capability Approach, on the other hand, is able to reflect these varieties of factors sufficiently in one framework.

The Capability Approach provides the basis to identify people polytomically rather than dichotomically by challenging the rhetoric that 'all men are created equal', and acknowledging the diversity of people in relation to their social contexts, which may provide different opportunities. These differences are reflected as personal factors within the comprehensive framework of Capability, without valuing neither positively nor negatively (Sen 1999). This provides two crucial implications and analytical views to the research on disability. Firstly, it implies that researchers tend to avoid the understanding of life and daily living of disabled people by distinguishing them as disabled people from non-disabled people in general. This implies that researchers need to emphasise the differences of the needs and aspirations of individuals rather than assuming them to be a homogenous group. Secondly, this leads researchers to analyse differences or inequality among disabled people by having a critical view of homogeneity

of disabled people but acknowledge differences within disabled people (Terzi 2003).

Based on these potentials, eight important implications in the analysis of disability are summarised as in Table 5. Each will be discussed below.

Focuses on all factors in three categories, commodity, social and personal factors, rather than focusing on only one of them

Table 5: Implications of the Capability Approach for the Analysis of Participation of Disabled People and Disability

- Focuses on all factors in three categories, commodity, social and personal factors, rather than focusing on only one of them.
- Does not take factors separately but transforms them into Functionings and Capabilities to reflect actual opportunities and freedom.
- Takes actual opportunities and equality rather than the formal form of opportunity.
- Analyses potentials and freedom rather than achievement or achieved conditions.
- Pays equal attention to the aspect of agency as well as well-being.
- Reflects the diversity of the aspirations of individuals and society rather than applying a preset list for analysis.
- Reflects different forms of disabilities.
- Identifies various areas of and strategies for intervention in practice.

The Capability Approach highlights the importance of understanding the well-being of people by reflecting three factors: personal, social and environmental factors. It also provides a framework which reflects all factors in one comprehensive picture. One's life and well-being is influenced by factors in these three categories and it is particularly important to analyse the participation of disabled people with regard to their personal and social conditions.

Does not take factors separately but transforms them into Functionings and Capabilities to reflect actual opportunities and freedom.

The Capability Approach reflects actual opportunities rather than traditional or institutional opportunities. Capabilities reflect actual potential or freedom to be or to do by transforming various factors into Capability. For instance, even if equal opportunity for the education of disabled children is assured in legislation, some disabled children may not be able to attend school due to poverty or uncontrolled epilepsy or because of family member's attitude. It may not be possible to understand actual opportunity for education due to these factors if it is assessed and analysed solely by institutions or legislation. Capability Approach ensures that a variety of factors are considered and provides a framework by the introduction of the concept of Capabilities.

Takes actual opportunity and equality rather than the formal form of opportunity

Capability Approach emphasises the understanding of actual opportunities directly, rather than assuming it indirectly by analysing means. Take, for example, formal opportunities to protect access to education through the implementation of a barrier-free environment or legislation to protect the rights to education of disabled children. Despite this, some children may not have actual opportunity for education due to other factors; individual or social, which influences the realisation of such Functionings and Capabilities such as poverty or distance to school. This emphasis on the analysis of actual opportunities directly implies the importance of researching the detailed background of one's life in relation to society rather than assuming it indirectly by focusing solely on an analysis of social institutions.

Analyses potentials and freedom rather than achievement or achieved condition

Capability Approach implies the importance of analysis of well-being and QOL by freedom or actual opportunities to realise various Functionings rather than actual achievement of such Functionings through the use of the concept of Capability. This is very important for the analysis of participation of disabled people as it allows for the use of potentials and possibilities in addition to actual achieved condition to analyse participation as equal opportunity. Opportunity for education or employment, for example, should not be analysed only if disabled people are currently attending schools or are employed, but also to be analysed if they can do so if they wished in particular

conditions. The meaning of the situation that a disabled child is attending a CBR centre instead of a school in a village can vary if attention is paid to actual opportunities. That is, whether that child has actual opportunities to attend school or not, and whether the decision is of that child and her family or school authorities.

Pays equal attention to the aspect of agency as well as well-being.

One of the key features of the Capability Approach is that it reflects both well-being and agency, which is personal commitment or action for good that is not beneficial to one's well-being, separately in a single framework without squeezing them into one (Sen 1992). Participation of disabled people as implementers or decision makers in the process of CBR, for example, may not necessarily improve their well-being but can contribute to the realisation of a better society.

Sen observed that it was his aim to explore a moral approach that sees persons from two different perspectives, well-being and agency although these are thoroughly interdependent. Both well-being aspect and agency have their own relevance in the assessment of status and actions and these two aspects are the central concepts in his Capability Approach (Sen 1992: 57; Jensen: 9).

Reflects diversity of aspirations of individuals and society rather than applying preset list for analysis

Although this aspect of the Capability Approach is often criticised as a limitation by various researchers, it is important that it reflects the diversity of individuals and

society. In contrast to Nussbaum, Sen does not propose a definite list of Capabilities. He reasons that such an attempt may tremendously over-specify human nature, and state the importance to preserve this ambiguity or flexibility to understand general Capabilities which may vary depending on one's own aspiration and the conditions of society (Yamamori 2003: 18). This, then, implies that the significance of understanding an individual's aspirations in relation to the social conditions can be highlighted using qualitative methodologies. These methods emphasise the understanding of the lives of individuals in relation to their social context in contrast to quantitative approaches that apply a standardised index to analyse the Capabilities of individuals. The strength of the Capability Approach is to make the selection of relevant evaluative dimensions an explicit social choice exercise, while the Medical Model of disability has a fixed and limited set of evaluative criteria (Mitra 2003: 23).

Reflects different forms of disability

As it will be discussed in the Family Model of disability, disability issues may influence different people in different ways, regardless of whether one is with or without impairments. Capability Approach reflects these different forms of disabilities accordingly and transforms them into Functionings to understand ones' condition holistically³. In the case of a disabled person, his or her impairments

3 For instance, anxiety is listed as one of the major issues for families of disabled people. This can be analysed as a Functioning of "having a life without fear and anxiety", and factors which raise this anxiety can be represented in three categories, e.g., financial limitation (commodity), lack of support in community (environment/social), or too old to look after a disabled child (personal), and transformed into Capabilities.

may be taken as a personal factor, but for his or her family, their physical or financial burden may be taken as factors of environmental factor and both are transformed into Functionings and Capabilities.

Identifies various areas of and strategies for intervention in practice

This feature of Capability Approach has both potentials and limitations. Capability Approach understands lives of people through the concept of Capability, which is formed from conversion factors, i.e., personal, social and environmental factors. As long as Functionings and Capability is improved, areas of intervention are not restricted. This leads to various areas of intervention in practice according to the conditions of society and capacity of intervening agencies. Taking the Functionings of “having education” of a disabled child who uses a wheelchair as an example; it is possible to see that the child’s Capability could be restricted for a number of reasons: if her family has enough money to send her to school (commodity), if she can push her wheelchair to local school (personal factor), or if the school is barrier free to accept her in her wheelchair. And this analysis leads researchers to identify areas of intervention and means of intervention to be decided according to possibilities, appropriateness and preferences of her and her family.

○ Consideration Points of the Capability Approach

As in all conceptual models, caution must be taken in its application of the Capability Approach. Various researchers have pointed out ambiguities and limitations of the Capability Approach (Cohen 1993; Qizilbash 2001).

Five limitations are summarised in Table 6. But before considering these it is important to address differences in terminology. These differences are not really a limitation of the conceptual framework, but it is the particular use of the terms in the framework which may mislead researchers.

A major limitation is the use of the term ‘disability’ in Sen’s work on the Capability Approach. Sen often used the term ‘handicap’ or ‘disability’ to explain a body function and structure or impairment as defined in the ICF or ICIDH. This refers to the physical and mental condition, rather than disability as an outcome of the interaction between the individual and society, which is in fact one of the Capabilities of Sen’s conceptual framework. The different use of the terms may create confusion and mislead researchers into incorrectly understanding disability as a condition of physical and mental ability only, not as an outcome of the interaction of individuals and society (Mitra 2003: 14).

Similarly, the term ‘Capability’ is given a unique meaning within the concept of the Capability Approach, a meaning which is different from the general usage of its term as an individual potential without referring to external conditions. Capability as a concept of the Capability Approach means the overall outcome of three conversion factors, i.e., individual, social and environmental factors. Those who do not clearly understand this usage of the term ‘Capability’ might be misled into understanding Capability Approach merely as a framework to analyse the aspect of individual ability without reflecting other social and environmental factors.

Table 6: Factors to be Considered When Applying the Capability Approach as a Framework for Analysis of the Lives of Disabled People

- Capability Approach may not provide a framework to analyse the causes of each factors.
- Capability Approach allows various areas and modes of intervention
- Capability Approach may not clarify actors of intervention.
- Difficulty in dealing with choices of people who have problems with decision making
- List of Capabilities/Functionings is not fixed

Although this framework provides a tool to analyse causes of condition of Functionings and Capabilities by reflecting the environmental, social and personal factors, it may not provide an analytical framework to identify causes of the condition of each factor. In order to overcome this limitation in this study, models of disability and a more detailed framework for analysis of participation will be used to compliment the analysis using the Capability Approach. For instance, the Capability Approach provides a framework that may reveal personal, social and environmental factors that are restricting a disabled child from attending school. However, it does not provide a framework for the analysis of why these factors are posing such restrictions. While the cause maybe that the school is not barrier-free, such causes are more appropriately analysed by the Social Model of Disability.

Related to the first limitation explained above, there is potential to deal with only interventions in personal domain such as impairment instead of finding the root

and fundamental causes of the restriction of Capabilities. This flexibility or capacity to accept diverse intervention may suggest interventions which may not be ideal for disabled people but may be preferred by those who provide intervention e.g., family, doctors, or teachers. This is certainly true in the case where rehabilitative interventions have been embraced to address disability based on the Medical Model regardless of choice of disabled individuals. Researchers need to bear in mind that Functionings and Capabilities arise from factors in all three categories; social, environmental and personal, and they need to seek the causes of restrictions in all three rather than in a single category.

Sen explained that intervention in the realm of Capabilities is development, and it can be explained as empowerment (Bhatia 2001). However, Sen does not imply who should take this role, e.g., government, civil society or people themselves, and how they should do so within this framework. In other words, actors of empowerment are not clearly defined. Although Sen criticised paternalistic interventions and emphasised the idea that people themselves should be change agents, he also notes the positive role of government and development agencies as interventionists into conditions such as poverty (Qizilbash 1996; Sen 2000). On the other hand, participation of primary stakeholders, i.e. disabled people, is one of the main concerns in the field of disability, and this aspect of policy may not be sufficiently emphasised in this framework.

Cohen commented that the Capability Approach brings conceptual confusion in evaluation by emphasising freedom in its framework (Cohen 1993). Cohen used the

example that babies do not choose to eat and drink for survival by their own will. Iwasaki also pointed out difficulties in reflecting the well-being of people with problems in decision making, e.g. people with learning disabilities or psychiatric problems, because well-being is analysed as freedom rather than achievement in the Capability Approach (Iwasaki 1997a). Sen himself agreed that it might be better to analyse well-being as achievement rather than as freedom in some of these cases (Sen 2000). Analysing well-being as freedom instead of achievement is the central feature of the Capability Approach, and denying the application of this notion to people with certain conditions implies fundamental limitation of this framework when applied to disabled people. However, as Iwasaki suggested, the ability of decision making varies regardless of disability or age in relation to social and environmental matters with regard to making decisions, and such ability in decision making can be reflected as a personal factor of Functionings of "making decision" (Iwasaki 1997b).

Although it is a positive potential to reflect an individual's aspiration into analysis, not using a predetermined list can also be a limitation of the Capability Approach to some extent as Nussbaum pointed out (Nussbaum and Sen 1993). For instance, it makes it difficult to compare Capabilities if there is no universal set of Capabilities. However, such comparison itself is criticised as incapable of reflecting individual aspirations. Qualitative inquiries which animate the life of people and comparing them within a detailed context may provide more useful insights (Albrecht and Devlieger 1999).

○ **Conclusion**

Similar to other frameworks of thought, the Capability Approach has several limitations. Despite these limitations, however, the Capability Approach provides a comprehensive framework to analyse disability through its integral view of people's lives and QOL. Capability Approach provides a useful framework of thought on disability with respect to two features. Firstly, it provides an integral and comprehensive analytical view of issues and conditions which have been analysed in separate frameworks and paradigms in the fields of social development and disability, by introducing Functionings and Capabilities as integral concepts which reflect and transform differentiated issues in these two different fields into one synthesised concepts of Capabilities. Secondly, it values both well-being and agency as two distinctive concepts but within one comprehensive view. By these features and potentials, participation of disabled people can be analysed not only in relation to the condition of disability but also in relation to the diversity of depth of their lives. This analysis is done by reflecting other dimensions which affect disabled people, such as gender or poverty, and the analysis centres not only in the aspects of well-being of persons but also as change agents.

Part 5

DET in the Majority World

KENJI KUNO

This section shares our experiences on the implantation of DET as a part of development practices in the Majority World. DET has become one of the imperative components and approaches of disability related projects of the Japan International Cooperation Agency (JICA), which is a government development agency of Japan.

Since DET was first applied in the project in Malaysia in 2005, DET become a concrete tool of a Twin-Track Approach to realise both empowerment of disabled people and enablement of society – the creation of an inclusive society by mainstreaming disability in development.

By 2012, DET has been adopted by JICA's disability related project in seven countries, namely, Malaysia, Philippines, Kyrgyzstan, Uzbekistan, Costa Rica, Thailand, and Pakistan. We have learnt the potentials, limitations, and challenges of DET in the field of "disability and development" through these experiences in the Majority World.

■ 1. Disability Equality Training (DET): Potentials and Challenges in Practice in Developing Countries⁴

○ Abstract

This paper reviews the analysis of the potentials and challenges of the implementation of the Disability Equality Training (DET) in the Asia and the Pacific Region.

As a potential of DET, seven elements were identified in two categories; as a disability education for non-disabled people and as an empowerment process for disabled people. These potentials are developed by two key features of DET, i.e. a firm and logical framework on disability which is based on the Social Model of Disability, and the methods used in DET, i.e. a facilitated participatory learning approach.

In contrast, eight elements were identified as challenges in the aspects of implementation of DET and training of DET trainers. These challenges are mainly due to the persistent influence of the Medical Model of Disability which is rooted in meritocracy and capitalism, and due to lack of awareness and legislative and of administrative support of rights in general.

4 This article was first published in the Asia Pacific Disability Rehabilitation Journal (Vol. 20, No.1, pp.41-51).

○ Introduction

The true nature of “disability” is neither the individuals’ mere functional limitations nor the difficulties of performance which arise directly from such limitations. “Disability” is oppression, discrimination, social exclusion and the restriction of participation. This view of disability as a social construct is called the Social Model of Disability, and removes the focus from the individual disabled person as being “the problem” and shifts the onus on to society to remove the barriers which prevent full inclusion and participation of disabled people.

This Social Model of Disability made significant impacts on the development of new disability agendas, such as the United Nations Convention on Rights of Persons with Disabilities, the International Classification of Functionings, Disability and Health (ICF) of the World Health Organisation, and the rights-based approach of the Biwako Millennium Framework of Action.

Disability Equality Training (DET) was originally developed by disabled people in the United Kingdom and has been implemented since the late 1970s as a means to promote an understanding of disability from this Social Model perspective (Campbell and Gillespie-Sells 1991).

This DET has been gradually taken as a practical tool for disability education to promote equal rights of disabled people in developing countries by several development agencies (Harris and Enfield 2003). Together, the Japan International Cooperation Agency (JICA) and the Department of Welfare Malaysia have developed

a wide range of human and material resources. These have been used in the practical implementation of DET to develop a comprehensive programme. This paper critically examines this development and implementation experience to discover the potentials and challenges of DET implementation in developing countries as development intervention on disability issues.

○ **1. Disability Equality Training (DET)**

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

To realise this aim, DET has two core objectives and components. The first one is to provide participants an alternative view of disability so as to examine it as a social issue, i.e. the 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 help participants develop their own concrete action plans to break and to prevent the building of barriers which hinder participation of disabled people in relation to their own work and daily lives. Often, so-called disability awareness seminars end up only containing the first one, and do not facilitate the development of the participants' actions. DET is neither a simple lecture to add knowledge of disability nor a critique of discriminative attitudes. DET aims to challenge one's sense of values of disability, and to facilitate the development of each participant's proactive action to break social barriers, i.e. assisting participants to be agents for social change.

DET equally values both its contents and process of learning. People do not change their actions and sense of values by being forced. These can be changed only if and when participants themselves become aware of their mistakes and the importance of alternative views and actions. Therefore both contents: the provision of a logical explanation of disability and the discovering process as methods in the learning experience, are equally important.

Therefore DET should not be taken as a tool for propaganda or agitation to impose the Social Model view upon participants. DET is, rather, an educational process to assist internal reflection within the participants, to critically (re)consider their perceptions of disability.

Disability equality training (DET):

- Takes disability as a social issue of rights, discrimination and equality, rather than the individuals' functional issues.
- Is based on the Social Model of Disability, not the Medical Model.
- Aims to support participants to discover causes and mechanisms which create disability (social oppressions); and to act to change society to be more just and inclusive, rather than simply changing superficial behaviours.
- Avoids using simulation exercises which merely lead to the understanding and emphasis of 'inability' and functional limitations of disabled individuals.

Difference between DET and DAT

DET is different from the traditionally practised disability awareness approach, the so-called Disability Awareness Training (DAT), which usually utilises impairments 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 the issues 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 why they are facing such problems and troubles. On the other hand, DET aims to help participants learn why such barriers are made, and how to break or 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, i.e. a "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. DET recognises that this is often a result of ignorance and indifference of the issues and needs of disabled people, rather than the intentional wish to act as such an 'oppressor' or 'discriminator.'

However, DET also emphasises the transformation from such a 'victimiser' position to one of a 'change agent.' This 'change agent' can reform society to become more inclusive by supporting the development of their own action plans through their own will and power.

DET pays more attention to why such disabling barriers are made rather than simply identify and make a list of such barriers; i.e., "why" you need to do it, 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.

Limitations of Simulation Exercises

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 (French 1992; Kiger 1992).

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 incapable or less-able, although this is certainly not the case for the many disabled people who lead 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 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 reasons such barriers are created, and facilitates action to break them and prevent their creation.

○ **2. Implementation of DET: Project by JICA and the DSW**

JICA and the Department of Social Welfare Malaysia (DSW) commenced a project for Capacity Building on Social Welfare Services for disabled people in 2005. This project has been designed based on the Social Model of Disability, and DET is one of the key components of the project in addition to the promotion of the Independent Living movement, Supported Employment (Job Coach system), and Self-Advocacy of persons with learning difficulties. In this project, five-day training courses for DET trainers were held three times over three years, and 41 people, all of them disabled people from Malaysia, Thailand, Singapore, Indonesia, Nepal, Bangladesh, Pakistan, Kyrgyzstan, Maldives, and Afghanistan, were trained as DET Trainers.

Manuals on DET are also published in this project as the “DET Manual Series”.

Trained DET trainers have implemented DET in their own countries, and conduct further local trainers’ training courses too. As a result, for instance in Malaysia, a low-fare airline company has DET as a compulsory module for training cabin crews and ground staff. DET is part of a leadership training course in Thailand and Pakistan. The Asia-Pacific Development Centre on Disability (APCD) in Thailand implements further trainer’s training together with those who were trained in this project. As a regional effort, the Asia-Pacific DET Forum was also formed in 2006 (www.detforum.com). Experiences of the implementation of DET in these countries have been accumulated and the potentials, challenges and steps for further development of DET are discussed in the network of the forum. The following sections make up the analytical summary of these discussions.

○ **3. Potentials of DET**

Two key categories and seven elements were identified as the potentials and advantages of DET implementation in developing countries. One category is the methodological advantage of disability education for equality to non-disabled people. Another is the potential as an empowerment practice for disabled people.

DET as Disability Education for Non-disabled People

Four potentials and advantages of disability education were identified. The first potential is the methodological

advantage of DET. Often, people show hesitation and repulsion to disability awareness and disability education programmes by having a feeling of being imposed upon to do something which they think “is not my business”, especially in private sectors. However, such negative attitudes occur less in DET because of its methodological advantage, i.e. the facilitated participatory learning approach which facilitates a self-discovering process in contrast to the other approaches which often fall into the trap of propaganda or self-righteousness.

The second is the advantage of DET to create a logical understanding of the Social Model of Disability. Often, the Social Model is misunderstood as it ignores issues of impairments and the importance of medical interventions. In fact, however, the Social Model does not deny these, but contrasts issues on impairments and issues on disability, with a clarification of the limitations of a recovery-oriented rehabilitative approach, and so shows the importance of a social change-oriented approach to the issues on disability. Logical explanations on disability and self-discovering methods reduce such misunderstandings in the process of DET.

The third potential is to make participants aware of disability as one of their issues. Proactive action plan making helps participants become aware of their own potential and power to change their organisations or community better through feasible efforts.

A fourth and important advantage of DET is that it helps each participant deal with their own negative attitudes on disability and disabled people constructively: It supports each to create a practical and concrete path to rebuild

an alternative sense of value by a facilitated participatory learning process. Action plan making plays an important role in this by giving the opportunity to each participant to create their own solutions to break down their own barriers in their work and everyday lives.

DET as Empowerment Process of Disabled People

DET provides three elements for empowering disabled people. The first is that DET gives disabled people a logical explanation on disability as discrimination and social exclusion, which they always faced as problems, but which many of them could not explain logically before. It also gives a logical explanation of the Medical Model of Disability's failure and limitation to understand and fight against the entity of issues on disability.

The second is that DET gives them a method through which to logically and simply explain the Social Model perspective to non-disabled people. This empowerment was apparent among participants of DET trainers' training. Contents (theory of the Social Model) and methods (facilitated participatory learning approach) are inseparable elements of DET.

The third is that DET builds a new positive and affirmative identity of disabled people by redefining their identity from the Social Model perspective. This contrasts to the inferior status which is usually made under the Medical Model perspective.

Examples of empowerment were often seen among the participants of DET trainers' training courses, since they gained a more comprehensive understanding on disability

from the Social Model perspective, and trained as trainers to become able to “explain” the Social Model by using facilitated participatory learning approaches. Some young disabled people who did not have much experience taking leadership roles before the DET trainers’ training course have started to play an active leading role not only in their organisation, but also as regional leaders. One such example is a young male participant with learning difficulties. He gained the confidence in trainers’ training to start work as one of 5 trainers of a regular disability training course for a private company, and became a resource person for the UN ESCAP meeting on self-advocacy in 2007.

The Social Model itself empowers disabled people. DET adds more by providing methods to use the theory of the Social Model practically. It becomes a tool to explain disability as social issues which can empower disabled people as educators and agents for change on disability issues.

○ **4. Challenges of DET**

Eight issues in two categories of concern were identified as key challenges to the implementation of DET in developing countries. The first category is the challenge for the implementation of DET; the second is the development of DET trainers. These challenges were caused by two fundamental reasons. First is the lack of awareness of human rights in general. Even the most basic human rights and security, such as freedom from poverty, are not secured in many of these developing countries. Hence political, legislative, and administrative supports for activities and programmes such as DET (which are based on rights-based approaches) are not given a priority in practice.

The second reason is that the Charity Model and Medical Model of Disability still dominate people's sense of values, which are bound up with meritocracy and capitalism.

Challenges in the Implementation of DET

The promotion of the Social Model of Disability faces challenges even in Western societies despite there being a general awareness of rights and well-prepared legislative and administrative measures. Many more difficulties and challenges are surely to be expected in implementing DET in developing countries, where awareness of human and civil rights and the necessity of legislative and administrative measures for these are limited. Also, poverty and other social issues are accumulated; involvement in a capital market economy is forced, with competition faced in a disadvantaged status; and there are many differences in terms of culture, religion and society to Western societies, e.g. civil and human rights and the concept of entitlements. These issues have caused further difficulties and challenges in implementing DET.

The first challenge is to shift the paradigm of welfare interventions from the first generation (Charity Model: Care-oriented approach) and the second generation (Medical Model: Recovery-oriented approach) to the third Generation (Social Model: Inclusion and Participation-oriented approach). This is the hardest challenge in most developing countries where care and rehabilitation are still the central interventions on disability. Promoting rights or a rights-based approach, i.e. denying charity-based approaches was controversial in practice in the societies where legislative and administrative measures to protect the life and rights of the vulnerable, including disabled

people, are not regulated, and charity and donations are the main sources of inflow. (It is quite difficult to distinguish charity itself and the Charity Model perspective on welfare and disability.)

Secondly, influences of religious dogma which often promote a charitable outlook also cannot be ignored in developing countries. Religious leaders often hold a strong influence in communities and expressing opposite thought to parts of religious doctrine is regarded as a challenge to the religion itself; and triggers various problems in the community.

Thirdly, in contrast to the care- and rehabilitation-oriented programmes, funding is quite limited to the educational programme on disability to the public. Often, such educational programmes are taken as a “free of charge” programme and DET trainers are not paid as professional trainers compared to other professionals.

How to deal with “charity”, religious thoughts and funding issues are on-going topics of discussion among DET trainers in our project.

Challenges in Human Resource Development

The first challenge is that there are not many disabled people who are fully aware of, and have a strong sense of, human rights. Even some disabled leaders and activists promote charity interventions, although they themselves choose the language of “rights”. Many Disabled Peoples’ Organisations (DPOs) still play a role as mere self-help groups and have not transformed into agents for social change for inclusive society yet.

The second challenge is that many disabled people cannot work as full-time trainers because DET trainers are not paid well as professionals. Disabled people who have their own jobs can spare their time for DET only on weekends, and even those who are working as staff of DPOs also have duties in their own organisations. It is important for the implementation of DET that it is funded or being paid sufficiently to secure disabled people the ability to work as professional DET trainers.

The third challenge is that the 5-day training is the minimum to train a DET trainer, who also needs further training on both the Social Model and methodologies of facilitated participatory learning (FPL) approaches. A three-day follow-up training as an additional course was conducted on FPL for Malaysian participants, and it covered several aspects on methodologies. Although the above-mentioned internet discussion group of the AP DET Forum is an alternative method of follow-up by exchange of experiences and information, actual follow-up training courses or extensions of the length of training courses are required to ensure the quality of trainers.

The fourth challenge relates to the third one. Most disabled activists and leaders are likely to be good propagators and agitators to fight for their rights. Although their better understanding on their rights is an advantage to be a DET trainer, being familiar with a rather "impeaching" style can be a challenge to overcome to be a good DET trainer in a methodological sense. DET is a facilitated educational process and the trainers' role is neither as an accuser nor crammer but a facilitator for the participants' discovery and learning process.

An accusing, oppressive situation by impeachments of the one in charge may be essential in disability movements, and DET is also born from such disability movements and shares the same philosophical foundation through the Social Model. However, DET takes different approaches for the same aim. Both are important but should be implemented appropriately. One such example is the case of a low-fare airline company in Malaysia. Public demonstrations to accuse inaccessibility of its services at the airport broke the barrier of the company. DET was then used as an educational tool for them to rebuild new and better foundations through which to make their services accessible. Therefore, sufficient training and lots of practice to acquire methodologies and skills of the FPL approach are vital to a good DET trainer.

Lastly, inaccessibility of transportation and training venues also restrict disabled trainers in conducting DET courses, although this can be a good opportunity to raise awareness of organisers on the importance of accessibility.

○ **Conclusion**

Most people's perceptions on disabled people are influenced by the Medical Model. This model is strongly rooted to capitalism and meritocracy, which are the dominant sense of values in current world society. Such perceptions seem much stronger in developing countries which are newly swallowed by the wave of globalisation and competition. Therefore, the Medical Model is not merely a 'model' of disability, but an intrinsic part of people's 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 thinking

critically of disability and to view their own sense of values from an alternative perspective. DET can help them to continue thinking, by posing problems and providing tools and a theory to examine disability.

DET is not a panacea. However, it is a concrete strategy and activity to promote the Social Model of Disability and rights-based interventions on disability. Experiences of implementation of DET in the above-mentioned countries show explicitly its potential to empower disabled people and raise awareness on disability from the perspective of human rights. There are lots of challenges to overcome in implementation, and therefore it is worthwhile to continue developing DET to be more appropriate to developing countries. It also has the potential to examine the larger dominant values such as meritocracy, capitalism and ablist⁵ from the values developed by disabled people themselves.

5 Ablism is discrimination in favour of the able-bodied.

■ 2. Disability Equality Training: A Strategic Approach in “Disability and Development”

Kenji Kuno, Naoko Ito, Junko Ohno, Yoko Ishibashi, Minoru Hiramoto, Naoto Ikeda, Yoko Isobe, Eunice Factor, Peter Tan, Ghulam Nabi Nizamani

○ Introduction

The potentials of Disability Equality Training (DET) as a concrete approach for empowering disabled people and creating an inclusive society by enabling non-disabled people to become allies of disabled people by becoming agents of change, have been recognised gradually in the “Global South” or “Majority World” in line with the recognition of the rights of disabled people by the enactment of the UN Convention on the Rights of Persons with Disabilities.

The Japan International Cooperation Agency (JICA), a Japanese government’s development agency, has developed thematic guidelines on disability in 2003 and modified them in 2009¹⁾. It took a twin-track approach, which implements both empowerment of disabled people and mainstreaming of disability into development, as a framework of practice. JICA has also recognised the potentials of DET and taken it as an effective approach to apply this twin-track framework into practice. By the end of 2011, DET has been adopted in the JICA projects in seven countries: Malaysia, Thailand, Costa Rica, Philippines, Kyrgyzstan, Uzbekistan and Pakistan. In these projects, the implementation of DET has contributed to both

empowerment of disabled people and creation of an inclusive society. In addition, JICA applies DET for internal staff training and as one of key modules in thematic training courses on disability for overseas participants. DET has become an essential component and approach in the field of disability of JICA, especially in the projects that dealing with empowerment of disabled people and inclusive social development.

Various regional disability-related agencies in the global south, such as the Asia-Pacific Development Centre on Disability (APCD), have also become aware of the power of DET and have been applying it in their training and programmes.

The potentials and effectiveness of DET have already been shown and recognised in the Global North where legislative frameworks on the rights of disabled people are established. However, the above-mentioned practices have also provided evidence that DET is effective even in the global south where such legal frameworks on disability are rather weak or unstructured.

In this article, we would like to explore the experiences on DET in disability-related development projects of JICA in order to provide readers some examples of implementation and outcomes made by DET in the majority world.

○ **DET Practice in the Global South**

There are 4 senior DET trainers and 107 DET trainers in 14 countries who were trained directly in JICA projects by March 2012. These trainers formed the DET Forum in

2005 and have been implementing DET independently or collaboratively with JICA projects in their respective countries. Their updated activities are accumulated in the DET Forum's webpage at www.detforum.com. The following are the brief summaries of the implementation of DET in JICA projects.

1) MALAYSIA



Project Title:

(1) Project for Capacity Building on Social Welfare Services for People with Disabilities (PWDs) in Malaysia; and (2) Project to Support Participation of Persons with Disabilities (Two consecutive projects adopted DET as a component of the projects.)

Counterpart Agency:

Department of Social Welfare, Ministry of Women, Family and Community Development Malaysia

Project Period:

(1) Project 1: July 2005 – July 2008; (2) Project 2: September 2009 – August 2012

Project Outline:

Project 1: To promote social participation, inclusion and empowerment of all PWDs by developing policies and services based on the concept of the Social Model of Disability. Five key components of this project were: Independent Living movement/programme, supported employment, DET, self-advocacy, and sign language interpreter training. Project 2: To promote social participation, inclusion and empowerment of all PWDs by implementing: supported employment (Job Coach) and DET. This is a consecutive project of Project 1, which was implemented from 2005 to 2008.

Aims of Adopting DET in the Project: As a concrete strategy to develop a foundation of the project, i.e. understanding



disability from the Social Model perspective. Key stakeholders of the project include policy makers, service providers, civil society and, of course, disabled people themselves. Another aim was to establish social recognition of disabled people as experts on disability by creating DET trainers as experts on disability education.

Objectives, Activities and Outcome of DET:

The Project set two targets: to develop sustainable human resource development and service implementation structure on DET in Malaysia; and to develop a network of DET trainers in the Asia-Pacific region.

For the first target, the following activities were held.

- DET Seminar 1 (19 November 2006 at Kuala Lumpur, 120 participants)
- DET Seminar 2 (13 January 2007 at Kota Kinabalu, 140 participants)
- DET Seminar 3 (19 November 2007 at Kuala Lumpur, 150 participants)
- DET Seminar 4 (5 December 2007 at Bangi, 60 participants, all disabled people)
- 1st National TOT of DET (Malaysia and Thailand; 19-24 November 2005, 15 trainees)
- 2nd National TOT of DET (Malaysia and Thailand; 5-15 January 2007, 14 trainees)
- 1st Regional TOT of DET (Afghanistan, Bangladesh, Indonesia, Kyrgyzstan, Malaysia, Maldives, Nepal, Pakistan, Singapore and Thailand; 17-25 November 2007, 18 trainees)
- 2nd Regional TOT of DET (India, Malaysia, Nepal, Papua New Guinea, Philippines and Thailand; 3-11 November 2010, 16 trainees)

- 1st Regional Training of Senior Trainers of DET (Malaysia, Philippines and Thailand; 1-12 November 2010, 4 trainees)

Also: a series of DET manuals, training modules, tools, programmes and methodologies were developed by the project. The following is a list of published manuals and training video on DET:

- Liz Carr, Paul Darke and Kenji Kuno (2008) *Training Them and Us: A Guide to Social Equality for Society*, Kuala Lumpur, Utusan Publications.
- Kevin McLaughlin and Kenji Kuno (2008) *Promoting Disability Equality: From Theory into Practice*, Kuala Lumpur, Utusan Publications.
- Sue Rickell, Yuko Yokotobi and Kenji Kuno (2008) *Disability Equality and Inclusion: Making A Difference – DET Resource Book*, Kuala Lumpur, Utusan Publications.
- Kevin McLaughlin and Kenji Kuno (2011) *Mempromosi 'Disability Equality': Dari Teori kepada Praktikal* (in Malaysian), Kuala Lumpur, Utusan Publications.



Some parts of these manuals can be downloaded from the DET Forum's web site at www.deforum.com.

A training video for problems in DET was also developed. It is viewable on YouTube (search by keywords: DET Forum & training video).

As an outcome of the above activities, the following agencies began to implement DET to improve their services to be more inclusive: Ministry of Finance, Ministry of Transport, University Malaya, Social Security Organisation, Attorney General Chambers, Ministry of Women Family and Community Development, Malaysian Railway, Kuala Lumpur City Hall, Prasarana (government own public transportation company), Malaysia Social Institute, Ministry of Human Resource and several DPOs and NGOs.

One major outcome was that AirAsia, a leading low-cost airline in Asia, has adopted DET as a part of regular training for newly recruited staff, and has one-day training conducted bi-weekly in the last 4 years. In addition, AirAsia has expanded DET training as localised follow-up training in Indonesia and Thailand in collaboration with Barrier-free Environment and Accessible Transport (BEAT), a network of disabled organisations.

Most of the above-mentioned DET have been conducted by these trained trainers, who are now recognised as professional disability trainers/educationists by stakeholders in Malaysia and other countries. Senior DET trainers and some DET trainers have started to train other DET trainers in their respective countries. In the first three years, we depended on external trainers from the

United Kingdom to conduct our TOT. However, since 2010, our local trainers have been conducting TOT. Some of the trainers became resource persons for JICA projects in their countries, too. A few DET trainers became members of a National Council for Persons with Disabilities which was duly established under the PWDs Act 2008 in Malaysia.

These trained DET trainers now have the expertise in the tools and activities to conduct suitable DET for various participants, from students to government policy makers. These manuals and training tools were utilised by other JICA projects to implement DET in their countries.

For the second objective, the DET Forum was established in 2005 as a network among JICA's trained DET trainers. From within Asia and the Pacific Region, the network later expanded to the Majority World. Now it has 107 members in 14 countries.



2) COSTA RICA



Project Title:

The Reinforcement of the System of Social Participation of Persons with Disability with community participation in the Brunca Region, Republic of Costa Rica, with focus on Human Security Project

Counterpart Agency:

National Council of Rehabilitation and Education

Project Period:

March 2007 – March 2012

Project Outline:

To promote the social participation system of persons with disability for inclusive development of the Brunca Region in Costa Rica. Five key components of this project are: Intersectoral Coordination, Rehabilitation Service, Supported Employment, Community Based Inclusive Development, and Empowerment of Persons with Disabilities.

Aims of Adopting DET in the Project:

- Empowerment of PWDs to be agents of change as facilitators to conduct disability-related training courses for the community; and
- Raise awareness on the Social Model of Disability and rights of disabled people in the project site (including service providers and civil society)



Objectives, Activities and Outcome of DET:

For the first objective: developing human and other resources and establishing a structure and policy to sustain DET implementation, the following activities were held.

- DET TOT (4-12 August 2009: 19 trainees)
- DET Trainers' follow up training (1st: 4 October 2010)
- DET Trainers' follow up training (2nd: 31 May – 8 June 2011)
- An English DET Manual developed by the JICA Project in Malaysia was translated into Spanish ("Promoting Disability Equality", by Kevin McLaughlin and Kenji Kuno, Utusan Publication)
- "Talk", a DET video made by the Disability Rights Commission, UK, was also translated into Spanish.
- A National DET Forum was formed, and 4 meetings were held to develop networking among trained DET trainers.





As an outcome, those trained DET trainers can conduct DET with locally developed training tools. The project also conducted a couple of introductory seminars on DET for the project counterpart agencies. As a result, two ministries, the Ministry of Education and the Ministry of Social Welfare adopted DET as a part of their programme and implemented it as their training on disability. The project also made a presentation on DET in the international seminar on rehabilitation in November 2009 as a part of the promotion of DET for the related agencies.

The second objective was that people in the community gained the Social Model perspective by attending DET. For this objective, a series of DET was conducted by trained DET trainers both in and out of the project site. As a result, 1,388 people participated in these DET sessions, including officers of various ministries, disabled people, their families, and people in the communities. As a result, understanding of disability from the Social Model perspective was promoted and those who attended were motivated to become agents of change to work with the project to develop an inclusive community.

3) Uzbekistan



Project Title:

Improvement of Social Protection and Rehabilitation of Disabled People in Uzbekistan

Counterpart Agency:

Ministry of Labour and Social Protection of Population of the Republic of Uzbekistan

Project Period:

June 2011 – June 2013

Project Outline:

Based on the achievements and lessons learnt from a previous project on CBR, this project aims to develop social capital amongst Disabled Peoples' Organisations (DPOs), "mahallas" (community organisations), and government agencies of different levels to equip them to practice the Community-Based Inclusive Development (CBID) approach in Uzbekistan in the near future.

Aims of Adopting DET in the Project:

DET has initially introduced to a DPO which was recently established as the result of intervention in a previous CBR project. This initial group of young disabled people are expected to disseminate the concepts of Social Model of Disability through DET to local *mahalla* residents, including disabled people and their families, staff of local *mahalla* administrations, officers of local government agencies, and other DPOs.





By adopting DET, the project had two aims:

- Empowering the conducting members of DPO and the DPO itself, so that they would be able to lead other DPOs towards the Social Model of Disability to counter the dominant Medical Model of Disability in the country.
- Social Model of Disability would be recognised and favourably perceived amongst the targeted population of DET, so that they would consider and practice positive changes in physical and social environments as important measures to create an inclusive community.

Objectives, Activities and Outcome of DET:

For the first objective, following activities have been implemented as the capacity development of DET Trainers:

- Introduction to DET TOT (18-20 October 2011: 9 participants); conducted by a DET Trainer of Kyrgyzstan who was trained within the activities of JICA project in Kyrgyzstan.
- DET TOT Introduction Follow-up session (30 October 2011: 4 participants)
- English DET Manual Book 1 and Book 2 which developed by the JICA Project in Malaysia were translated into Uzbek ("Promoting Disability Equality", by Kevin McLaughlin and Kenji Kuno, Utusan Publication)
- "Talk", a DET video made by the Disability Rights Commission, UK, was also translated into Uzbek.

Activities for the second objective have been implemented in the form of DET sessions for the community members by participant of introductory DET ToT. Although those participants are able to conduct sessions consisting core concept of DET, there is still room for improvement. Therefore, full DET TOT is planned to be implemented within the period of the project.

4) Kyrgyzstan



Project Title:

Inclusion of Persons with Disabilities into the Society in Kyrgyz Republic

Counterpart Agency:

Ministry of Labour and Social Development (Reorganised into the Agency of Social Security during the period of the project)

Project Period:

September 2007 – March 2010

Project Outline:

Project aimed at promoting the inclusion of persons with disabilities into society through organising and enhancing Disabled People's Organisations' self-initiated activities and strengthening their partnership with civil society.

Aims of Adopting DET in the Project:

It was essential to shift the policy and understanding of disability into that based on the Social Model of Disability in order to realise the goal of the Project. First of all, PWDs themselves must overcome their internalised individual model which was influenced by the socialist policy and structure. Therefore, DET TOT for the disabled leaders was taken as one of the programmes of the Project. Application of DET aims to spread the Social Model perspective by implementing DET to increase awareness of disability for civil society and other government agencies.





Objectives, Activities and Outcome of DET:

To raise awareness of the importance and effectiveness of DET among project stakeholders, the following seminars and workshops were held.

- Seminar on DET (Bishkek, December 2007, 15 participants)
- Workshop on DET and orientation to Capacity Development of Self-help Organizations of Disabled People (CDSHOD) (Bishkek, May 2008, 20 participants)
- CDSHOD (Bishkek, October 2008, 80 participants)
- One day seminar on DET (Bishkek, 2 February 2009, 80 participants)
- Roundtable on Disability Equality issue with mass media (Bishkek, September 2009, 25 participants)
- DET and gender seminar (Tokmok, September 2009, 25 participants)
- DET and gender seminar (Karakol, September 2009, 25 participants)
- DET and gender seminar (Osh, October 2009, 25 participants)
- DET Training for medical staff (Bishkek, 20 participants)

To develop human and other resources to implement DET, the following activities were done.

- Sent a disabled person to a DET TOT at Kuala Lumpur, Malaysia, which was held from 19 to 23 November 2007
- National DET TOT (Bishkek, 2 - 7 February 2009, 10 trainees)
- Sent a DET trainer for a DET workshop in CBR Training in Uzbekistan, June 2009
- An English DET Manual developed by the JICA Project in Malaysia was translated into Russian ("Promoting Disability Equality", by Kevin McLaughlin and Kenji Kuno, Utusan Publication)
- "Talk", a DET video made by the Disability Rights Commission, UK, was also translated into Russian.

As a result, 11 DET trainers were trained and are able to conduct DET nationally. In addition, a few DET trainers have conducted introductory DET TOT for Uzbek participants. Implementation and acceptance of DET in these central Asian countries suggest that DET is applicable in countries from the former Soviet Union.



5) Philippines



Project Title:

Creation of a Non-Handicapping Environment (NHE) for Persons with Disabilities (PWDs) in the Rural Areas Project

Counterpart Agency:

National Council on Disability Affairs (NCDA)

Project Period:

October 2008 – September 2012

Project Outline:

The Project aims to get two pioneering municipalities in close collaboration with NCDA to create a Non-Handicapping Environment (NHE) in the rural areas, where physical and social accessibility (built-environments, legislation and people's attitudes) are promoted. Both pioneering municipalities are in the rural areas of the Philippines with a population of 25,000-45,000 which include farmers and/or fishermen. The areas targeted are: 1) New Lucena, Iloilo Province, Panay Island, and 2) Opol, Misamis Oriental Province, Mindanao Island.

Five key components of this Project are:

- Establishment of implementing/monitoring mechanism at the national and local level
- Profiling on PWDs and physical access situation in the pioneering municipalities
- Capacity development (training programs to enhance physical and social accessibility)
- Advocacy on accessibility and the rights of PWDs, and
- Networking with national and international organisations to promote NHE.

Aims of Adopting DET in the Project:

To raise awareness regarding disability, based on the Social Model perspective. Also, to motivate people to become agents of change among various stakeholders within a community and facilitate critical consciousness for the empowerment of people. Municipalities, disabled people and people in the community will, therefore, collaborate

to develop a non-handicapping environments based on the Social Model perspective (i.e., by realising a barrier-free environment in the physical, legislative and attitudinal sense).



Objectives, Activities and Outcome of DET:

Two concrete objectives were set as an implementation of DET. For the first objective, to empower disabled people as main actors to realise NHE promotion, the following activities were done.

- DET TOT (7-14 September 2009, 17 trainees)
- DET TOT Follow-up Workshop (8-9 March 2010, 15 participants)
- Sent a DET Trainer to DET Senior TOT which was held in Malaysia (1-12 November 2010)
- Sent 2 disabled people to a DET TOT held in Malaysia (2-11 November 2010)

As a result, more than 15 DET Seminars were conducted by 6 DET trainers in various regions, including the following for disabled participants.

- DET Seminar (Opol, Misamis Oriental Province, 5 December 2009, 21 Disabled Persons)
- DET Seminar (Metro Manila, 19 February 2010, 14 Board Officers and Members of the Cerebral Palsied Association of the Philippines Inc.)
- DET Seminar (New Lucena, Iloilo Province, 23 July 2011, 14 Disabled Participants)



Materials are localised in terms of contents and language (Tagalog). By participating these DET sessions run by trained DET trainers, disabled people in the community have started to internalise the Social Model perspective and overcoming negative self-images, and being motivated to participate in DPOs and other activities in the project, such as peer-counselling or leadership development courses..

For the second objective, to motivate non-disabled people into becoming allies and actors to promote NHE, the following activities were implemented.

- DET Seminar (Antique Province, 23 November 2009, 40 Municipal Officers along with Disabled Participants)
- DET Presentation (Metro Manila, May 5, 2010 Special Education (SPED) Teachers)
- DET Presentation (Metro Manila, June 2010 Special Education (SPED) Teachers)
- DET Presentation (Metro Manila, July 12, 2010 Physical Therapy Graduating Students)
- DET Seminar (Opol, Misamis Oriental Province, December 17, 2010, 16 Barangay Officials)
- DET Seminar (New Lucena, Iloilo Province, 25 February 2011, 36 representatives from 21 Barangays)
- DET Seminar (New Lucena, Iloilo Province, 30 April 2011, 40 representatives from 3 key Barangays)
- DET Seminar (New Lucena, Iloilo Province, 24 July 2011, 16 Parents of Disabled Persons)
- DET Seminar (Opol, Misamis Oriental Province, August 12, 2011, 16 Barangay Officials)

The results will be evaluated by the end of the project.



6) Thailand

Project Title:

Asia-Pacific Development Centre on Disability (APCD)
Project (Phase 1 & 2)

Counterpart Agency:

National Office of Empowerment for Persons with Disability,
Ministry of Social Development and Human Security

Project Period:

Phase 1: August 2002 - July 2007; Phase 2: August 2007 - July
2012

Project Outline:

The APCD Project was formed in Bangkok, Thailand to promote the empowerment of persons with disabilities and a barrier-free society in developing countries in the Asia-Pacific region. The 1st phase of the project aimed to establish the APCD as a regional centre to play a role in 3 key areas (1) human resource development of persons with disabilities in the Asia Pacific (training), (2) information support, and (3) networking and collaboration since August 2002. The 2nd phase which was started in July 2007 designed to strengthen these areas towards more effective and sustainable networking and collaboration among the APCD, focal point organisations, associate organisations and other relevant organisations.

Aims of Adopting DET in the Project:

As mentioned, training is one of the key areas of APCD project and the “participatory training approach” is the heart of APCD training design to promote the empowerment of persons with disabilities and the creation of an inclusive society in the Asian-Pacific region. Trainees from Asia Pacific tend to have different knowledge, attitudes and skills on disability based on their different experiences. Therefore, to ensure them to clearly understand different disability models and to be fully equipped to join rest of the training modules, DET has been applied as an introductory module of APCD international training courses.

Objectives, Activities and Outcome of DET:

As mentioned, DET was taken as an introductory module in the APCD international training course. As a result, trainees deepened their understanding on different disability model particularly Social Model which perceives that disability is an oppression, discrimination, social exclusion and restriction from participation which is socially constructed and imposed upon, at the beginning of the course. It is particularly reported that DET contributed to develop shared understanding of and attitudes toward disability as a foundation of discussion on disability among participants from ex-trainees, APCD staffs, and resource persons of DET. It should be also noted that currently, APCD also plays coordinator role of the DET and Disability Related Service Training (DRST) for AirAsia Thailand.

7) Pakistan



Project Title:

Project on the Promotion of Social Participation for Persons with Disabilities (PWDs)

Counterpart Agency:

Federal level – Directorate General of Special Education, Ministry of Social Welfare and Special Education: Province level – Zakat, Ushar, Social Welfare and Women Development Department, District level – Abbottabad Social Welfare and Woman Development Department

Project Period:

December 2008 – November 2011

Project Outline:

Project aimed to promote Social Participation of PWDs, both men and women, in the Abbottabad district; extend its activities to other Districts; and contribute to the implementation of the National Plan of Action (NPA) for PWDs. Main expected outputs are: (1) Network building between federal, provincial, district governments, and NGOs, (2) Organisation and strengthening of Self-Help Groups (SHGs), DPOs, family groups, (3) Reduction of discrimination and prejudice against PWDs, and (4) Improvement of Information Accessibility for PWDs.

Aims of Adopting DET in the Project:

DET was applied to help raise awareness on the importance of SHGs and DPOs, leadership training of persons with disabilities, and capacity development of project team members.



Objectives, Activities and Outcome of DET:

A two-day introductory level DETTOT was held on 2-3 March 2011 for four participants. As a result, these trained trainers can conduct basic DET sessions. These trained trainers conducted basic DET sessions, which were adapted to local socio-economic background and language, in a part of the leadership trainings of persons with disabilities and family members in June 2011. More than 130 persons with disabilities and family members participated in the training.



For the awareness raising and capacity development, DET was applied as a part of the following 10 training courses and workshops. Mr. Ghulam Nizamani who attended DET TOT in Malaysia in 2008 cooperated in the implementation of DET in these courses.

- DET Basic Session for Project Team Members (2009, 2010)
- DET TOT Training for Project Team Members (2011)
- 1st Leadership Training of Persons with Disabilities and family members (2010)
- 2nd Leadership Training of Persons with Disabilities and family members (2010)
- 3rd Leadership Training of Persons with Disabilities and family members (2011)
- 4th Leadership Training of Persons with Disabilities and family members (2011)
- 1st Leadership Training of Family members, Lady Health Workers and Primary School Teachers (2011)
- 2nd Leadership Training of Family members, Lady Health Workers and Primary School Teachers (2011)
- Leadership Training for the Blind (2011)
- Leadership Training for the Deaf (2011)

It was also difficult to evaluate impact of DET itself, since it was implemented as a part of a series of training modules and workshops.



○ **Conclusion**

I would like to conclude this section with the following four perspectives.

(1) Aim of applying DET in disability related projects

DET was adopted by most projects to shift stakeholders' understanding of disability from the individual model/paradigm to the Social Model, which includes both disabled and non-disabled people. It is often reported that even disabled people internalise the individual model. Some projects, e.g. the projects in the Philippines and Kyrgyzstan, included the enablement of the community to be agents of change to realise an inclusive community in the scope of the project and DET. As the projects in Thailand and Malaysia show, DET has become a tool to develop a foundation on disability for participants of disability-related training courses and project stakeholders.

(2) How DET is applied in the projects

All projects consist of two components in the process of implementing DET: resource development (human, material, etc) and development of sustainable environment to implement DET (system and structure). As projects in Pakistan, Uzbekistan and Kyrgyzstan showed, training of trainers (TOT) of DET is not merely a human resource development on DET, but also leadership development for disabled people. Projects in Malaysia and Philippines have shown that the process of developing a sustainable system of DET itself is a process of creating an inclusive community. A project in Thailand showed that DET can be applied

as a module to develop a foundation for understanding disability.

(3) What are the outcomes of DET

For human resource development, most DET TOT in the projects succeeded in training local trainers, which ensured the sustainable implementation of DET without external inputs or supports.

Other developed resources, e.g. manual, modules and training tools, were done by localising materials developed by the project in Malaysia and other DET resources from other agencies. Although the foundation of DET is the Social Model of Disability and FPL, localisation of both content and methodology is crucial. The development of a national DET network was also adopted and made a part of a system to ensure sustainable development of DET in each country.

Most projects have shown that DET can be conducted sustainably by local trainers with the necessary training tools. Such outcomes also leads to impacts such as the enablement of the community to be agents of change to create an inclusive society. One good example is the case of AirAsia and BEAT of Malaysia. DET also enabled DET Trainers to become active leaders on disability in general. Social recognition of DET trainers as experts or professionals on disability was also identified as an outcome of the implementation of DET. Participation of disabled people in the process of decision making is promoted more by this recognition, rather than merely participating as users or consumers of disability-related services.

(4) Challenges in DET

Challenges in DET implementation in the project can be summarised into these three concerns:

Quality of DET:

It was reported that not all trained DET trainers were able to provide satisfactory level of DET to suit to the needs of participants and purpose of the training. A two-week DET TOT which was provided to this project/these projects put participants on a path towards becoming a DET trainer but not to make all participants “perfect” trainers. To become an effective DET trainer, continuous self-learning and development are essential. Local DET trainer networks and follow-up training courses helped initiate such developments. However, a firm professionalism as a disability educationist is required for the development of both individual and groups of DET trainers.

Evaluation of outcome of DET:

It was rather difficult to evaluate and assess the outcome of DET. DET does not merely aim at accumulation of knowledge on disability but also the enablement of participants to be agents of change. i.e., evaluation of DET must be made from the perspective of how participants become agents of change to create an inclusive society with regards to disability. Merely relying on evaluation methods/tools to measure attitudinal changes towards disability, e.g. Attitude Towards Disabled People (ATDP) and Modified Issues in Disability Scale (MIDS) cannot determine if such processes are agents of change. Both quantitative

and qualitative methodologies to evaluate the impact of DET must be developed.

Ensuring sustainable application of DET:

Although almost all projects succeeded in developing sustainable circles of DET in terms of implementation, i.e. training DET trainers to provide DET without external inputs. However, another essential element to sustain local DET development, i.e. sustainable local DET trainers training, cannot be developed fully even by the project in Malaysia, which led other countries' development of DET. The project in Malaysia succeeded in training senior DET trainers who can work as co-facilitators of DET TOT but not as main facilitators of DETTOT. Such a level of training may be difficult to reach within the ordinary period of the project, i.e. 3-5 years. Therefore, it may be more appropriate for training to be tailored according to regional or international levels, rather than by country.

Logical advantages and potentials of DET were identified by these practices. However, challenges in the implementation in the form of the project were also seen. Although such challenges must be overcome by the strategy in the project, development of a framework, approach or system beyond the boundary of the project may also be considered.

Experiences from these seven projects provide examples on how DET was applied and resulted in shifting the projects' stakeholders' disability paradigm from the individual model to the Social Model, and make people agents of change by facilitated participatory learning (FPL). DET is effective

as a process of emancipation for PWDs and creation of an inclusive community for government and civil society.

A framework and approach of DET has a high affinity for two key frameworks in disability and development, i.e. UN Convention on the Rights of PWDs, and the CBR Matrix. DET can be used as a tool to enable society to be more inclusive and to empower PWDs as agents of change. It is unique but also a natural result that JICA is gradually applying DET as a key component of most of its disability-related projects, especially ones which work on developing inclusive communities and empowering PWDs.

However, the outcome of the application of DET is heavily dependent on the quality of the DET, i.e. skills and attitudes of DET trainers in addition to the contents of training materials. Therefore, “doing DET” does not ensure the expected outcomes, if the quality of trainers is absent. The quality of trainers’ training is crucial in applying DET in the work of disability and development in the majority world.

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Postscript

The original writing for book was written as part of a UK National Lottery funded project – for which we as the writers were very grateful. But no book is worth anything if it is merely read. It needs to be disseminated and lived. Equality is not something offered to someone else who is seen as less equally than you are: equality is the absolute intrinsic right of all people (disabled and non-disabled; black and white; male and female; adult and child; and everybody else). For too long disabled people have waited to be given equality – now is the time to take it. Hopefully this book will give disabled people and non-disabled people the tools to take equality to a new level.

All that is written in the book is written on the basis that society is not naturally inequitable. People, and their societies, are naturally just. It is only in the last few hundred years that societies have been distorted by capitalism, religion, industrialisation and, more recently, the media (in all its forms). As such, this book is an optimist's guide to achieving equality and – logically following on from that optimism – it is mainly optimists who will use and benefit from it. Never be afraid to see the optimist in even the most cynical pessimist (the spark of hope – like love and democracy – is waiting to be lit in the darkest of corners of the blackest room in the gloomiest neighbourhood). This book will hopefully have been your map, your guide, through the shadows of despair right through to the hope of a better future.

In reading this book, we hope that you have not been 'put off' the drive to equality, nor that it has made you feel that its instructions must be adhered to by the letter. Each individual, group or organisation may come to equality by a

different path and they may need to take a slightly different route to go as far down that road as possible. This book should be used as a starting point for your own creativity, wit and approach as long as you stick to its principles. Do not be afraid to take what it suggests and take it further or to tone it down: feel free to make your advocacy for equality more challenging or less challenging depending upon the people you are working towards equality with. Do not be afraid to tailor the training to suit your needs and those you may be training. You can, and should, use your strengths and the strengths and awareness of those you train to achieve as much awareness and equality as is possible today. Do not be put of by failure: equality is a right but one which few are ready for today; but they will be tomorrow if you did today right.

Paul Darke

