



How may healthcare and social workers contribute to dismantling disabling barriers?

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Abstract

In their line of duty, all healthcare and social workers may encounter persons with disabilities as clients, service users or patients. Usually, the context will be public or private services that have a duty to promote inclusive equality. In turn, inclusive equality depends on accessibility and accommodation.

Healthcare and social workers' first challenge is to ensure that the services they provide are accessible. Persons with disabilities should not experience the services as less useful or more strenuous to access than other people do. A second challenge is when taking part in designing interventions for persons with disabilities, healthcare and social workers need to consider that the problem they aim to solve or alleviate may arise from features of the context where the problem presents itself, as well as from features of the persons themselves. Taking for granted that it is they who must adapt to the context may contribute to upholding discriminatory conditions.

Responding adequately to these two challenges requires insight into what features of environments may constitute disabling barriers for persons with different types of disabilities. Based on Norwegian and international studies that examine the experiences of persons with disabilities, this article formulates nine research-informed suggestions for how healthcare and social workers may contribute to dismantling disabling barriers to promote a more accessible and inclusive society for persons with disabilities.

Keywords

discrimination, disabling barriers, impairment, accessibility, service provision

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Introduction

Disabling barriers

The term 'disabling barriers' has been circulating in Norwegian official reports and white papers since NOU 2001: 22 'From service user to citizen: A strategy for dismantling disabling barriers.' The point is that, in any given situation, the physical and social environment will influence how disabled a person with an impairment becomes:

It is obvious that if stairs are replaced with ramps and lifts, a wheelchair user will be less disabled. Similarly, deafness is not very disabling in environments where everybody knows sign language, and intellectual disability is less disabling in less complex societies where only a few can read and write». (NOU 2001: 22, p. 7, my translation)

Disability is here understood as a relationship between individual and environment: Where an impairment is a relatively stable feature of the person, *disability* becomes something that will vary with the environment.

Similarly, the UN Convention on the Rights of Persons with Disabilities (the CRPD), describes that disability «results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others» (UN, 2006). Also here, disability is understood as a relationship between individual and environment.

Both quotes suggest a way forward: For persons with disabilities to have the opportunity of participating in society on an equal basis with others, disabling barriers must be built down. But what does this mean in practice? In particular, what does it mean for healthcare and social workers, who neither build ramps and lifts, nor have the authority to get 'everybody' to learn sign language, or can, should, or would want to work for 'a society where only a few can read and write'?

As a healthcare and social worker, and academic, I have had a long-standing interest in such questions. As a curriculum decision-maker in higher education, I have missed a paper addressing how specific aspects of physical and social environments may become relevant as barriers for persons with different impairments, and how healthcare and social workers may contribute to dismantling them or lessening their impact. Hence this article. In what follows, I focus very little on 'attitudinal barriers.' My focus is what the CRPD referred to as 'environmental barriers' – environmental circumstances that may arise through practices at individual, group, and societal levels, and may contribute to people with disabilities being disadvantaged, but cannot be readily attributed to negative attitudes. As we shall see, such practices may lead to social as well as physical disabling barriers.

The responsibility of healthcare and social workers

The Norwegian Equality and Anti-Discrimination Act states that one of its aims is to «help dismantle disabling barriers created by society and prevent new ones from being created», and that «[e]quality presupposes accessibility and accommodation» (Equality and Anti-Discrimination Act, 2017, §1, my translation). Furthermore, the act outlines two forms of accommodation: universal design and individual accommodation.

Public and private sector organizations aiming to serve the general public have a duty to implement universal design. In a Norwegian legislative context, this means

designing or making accommodations to the main solution with respect to the physical conditions, including information and communications technology (ICT), such that the general functions of the undertaking can be used by as many people as possible, regardless of disability (Equality and Discrimination Act, 2017, §17).

However, universal design may be insufficient alone; «... human diversity is so great and barriers so varying, that more working methods and measures are needed to create an inclusive society. Therefore, individual accommodation is a statutory right», Lid (2013, p. 152, my translation) writes. In Norwegian legislation, children with disabilities have a right to

«suitable individual accommodation in respect of municipal day care facilities», and persons with disabilities have a right to «suitable accommodation in respect of individual long-term municipal care services provided pursuant to the Health and Care Services Act» (Equality and Discrimination Act, 2017, §20). In schools and higher education, pupils, and students with disabilities «have a right to suitable individual accommodation in respect of the place of learning, teaching, teaching aids and examinations» (Equality and Discrimination Act, 2017, §21). «Workers and job seekers with disabilities have a right to suitable individual accommodation in respect of recruitment processes, workplaces and work tasks» (Equality and Discrimination Act, 2017, §22).

Healthcare and social workers involved in adult day care or support in daily life may play a role in such accommodation. Healthcare and social workers involved in healthcare or welfare services may play a role in contributing to such accommodation in schools, higher education, or workplaces, as part of their support to clients, service users or patients. In all of these arenas, as well as in the design of the support itself, an important element will be to counteract *indirect discrimination* – “any apparently neutral provision, condition, practice, act or omission that results in persons being put in a worse position than others» (Equality and Discrimination Act, 2017, §8). The CRPD obligates Norway to «promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights» (UN, 2006, §4).

Thus, whether they work in public and private sector organizations, healthcare and social workers have a part in fulfilling persons with disabilities’ right to participation on an equal basis with others. This does not only require knowledge of persons with disabilities’ rights; it requires insight into the features of societies and arenas that may constitute disabling barriers – the main theme of this article. So, what sources do I use to exemplify such barriers?

My sources

This article is based on a series of searches in the academic search engine Google Scholar in 2016, 2017 and 2018 with the keywords «disabling barriers» in English and Norwegian. My search strategies were not random, yet neither were they as comprehensive as systematic or scoping reviews require. Thus, this is a professional article compiling examples from 37 Norwegian and international research studies. In turn, these 37 studies were selected after reviewing approximately 400 search results. From these results I selected all studies that reflected persons with disabilities’ own experiences with disabling barriers. In this article I refer to examples from persons with physical, sensory, cognitive, or mental disabilities, or dyslexia, or autism.

Most of these studies were conducted in the USA, the UK, or Norway. Compiling examples from different contexts is not unproblematic. At the same time, I will argue, three elements contribute to justifying it in this case: First, despite significant differences in both culture, legislation, and welfare systems, these countries have common features as Western, industrialized countries. Second, the type of impairment itself provides guidance as to which features of the environment may constitute barriers. Looking back at the examples from NOU 2001: 22 – while a staircase may be a disabling barrier for wheelchair users, it will not be for deaf persons. A disabling barrier for deaf persons may be the communication practices of the hearing majority, which, being auditory in nature, hinder their access to conversations and information. Disabling barriers for persons with intellectual disability may also have to do with information but related to its complexity – the opportunity to utilize the information – rather than access to the information itself. Thus, the experiences of wheel-

chair users, deaf persons, and persons with intellectual disability – as citizens in societies that are built and performed as if all of their citizens walk, hear, and have average intelligence – may be more comparable across national borders than national contextual differences would suggest. A third element contributing to justifying my compilation of examples from widely different contexts, is that they can never be more than clues in healthcare and social workers' ongoing quest to understand how they can best assist and support the specific disabled client, service user or patient in front of them: Ultimately, it is this person who is in a position to define or show what environmental features weaken his or her opportunity to participate on an equal basis with others.

In what follows, I consider first physical barriers, then social barriers. Social barriers are divided into experiences from public spaces, school and education, work life, leisure and experiences while receiving services and support. In the last part of the article, I discuss how healthcare and social workers may contribute to a more accessible and inclusive society.

Physical barriers

Sidewalks, stairs, and uneven surfaces such as cobblestones mean that wheelchair users and people who use walking aids both must take detours and plan more than others, because they need to consider the inaccessible parts of urban spaces (Bromley, Matthews & Thomas, 2007, p. 234). Steps or curbs can make it difficult or impossible to enter stores, banks, or cafés for a wheelchair user. The person may need to visit several places to find one that is accessible, or call for help from the front door, which can be humiliating (Layton, 2012, p. 7). Staff may have so little knowledge about accessibility, that the person risks not being able to enter the store even after having called ahead to check that it was accessible (Saltes, 2017, p. 84). And even if it possible to enter the store, it may be inaccessible due to things on the floor and the location or height of shelves and the checkouts. Fitting rooms may be impossible to get to or into, and so may toilets (Bromley et al., 2007, p. 234). Major barriers in public transport are related to getting on and off. Particularly buses may be inaccessible due to a combination of the design of the bus, the design of the bus stop, and factors such as that the bus driver needs to stop a certain distance from the curb for the ramp to be extended (Bjerkan, 2010, p. 39; Braarud, 2012, p. 84). Accessibility can be fragile, as when the transport itself is accessible, but lifts and automatic doors on the way in are out of order (Layton, 2012, p. 6; Saltes, 2017, p. 90) or snow or ice has not been removed from platforms and bus stops (Braarud, 2012, p. 84). Only a third of Norwegian homes are accessible to wheelchair users (Statistisk Sentralbyrå, 2015). This may cause significant difficulties in visiting friends or require the person to take account of not being able to go to the toilet during the visit. The same applies to cafés and nightclubs (Taub, McLorg & Bartnick, 2009, pp. 205–206). Wheelchair users may rely on help from their friends, but will then be dependent on their goodwill, in ways other people are not (Layton, 2012, p. 4). Gyms may be inaccessible because the placement of equipment makes it difficult to get around the room, and because the equipment is not designed to fit all types of bodies (Richardson, Smith & Papathomas, 2017, pp. 284–285).

Snow and ice on sidewalks, platforms and stops may threaten accessibility for people with a visual impairment, and many ticket machines with touch screens are useless because they neither have Braille or auditory information (Endresen, 2013, p. 62). Open interiors, which are ideal for wheelchair users, may make spatial orientation difficult for people with visual impairments, and automatic doors that swing open may create hazardous situations (Newton, Ormerod & Thomas, 2007, pp. 616–617).

Door phone access systems create inaccessibility in several ways: physically, for wheelchair users who cannot reach them, and information-wise, for people with visual impairments

who cannot see them, and people with hearing impairments who cannot hear if they get an answer or what people answer (Newton et al., 2007, p. 615). The problem arises when undertakings focused on the public choose systems of access control that do not ensure equal access for all citizens. In Newton et al., a person with a hearing impairment describes struggling to get into a building for her job interview: It took her over ten minutes just to get into the building. She panicked while waiting and was so late that she did not have time to collect herself before the interview (2007, p. 615). Another way jobseekers with disabilities are affected by disabling barriers, is that, in deciding what jobs to apply to, they must not only consider their own qualifications, but the accessibility of the workplaces as well (Newton et al., 2007, p. 617).

Lack of standardization of visual symbols in public spaces and public transport give people with intellectual disability less opportunity to orientate themselves than others (Nind & Seale, 2009, p. 281). Unclear signage may increase the stress level for people with mental illness, such as «Tom», who may panic if he struggles to find his way but manages well if the signage is clear (Newton et al., 2007, p. 615).

Limitations in universal design

Lid writes: «Environments give prerequisites and opportunities by facilitating participation. Their specific design suggests who they accommodate and who they may not accommodate» (2013, p. 32, my translation). Used in this way, the term «accommodation» no longer means «accommodation for persons with disabilities»: rather, Lid points out that accommodation is a universal phenomenon: Anything that is built or designed – urban spaces, shops, banks, cafés, buses, trains, planes – is already adapted. The question is whom it is adapted to. Simply put, society has largely been shaped in ways that match the functional abilities and needs of a majority, at the expense of functional minorities' opportunity to participate and fulfil their needs. From this perspective, universal design and individual accommodation become ways of rectifying injustice. But the means to rectify such injustice are not necessarily in place yet. Regarding universal design, «[p]ublic undertakings and private undertakings focused on the general public have a duty to ensure that their general functions have a universal design» (Equality and Anti-Discrimination Act, 2017, §17). In a Norwegian context, universal design means

designing or accommodating the main solution with respect to the physical conditions, including information and communications technology (ICT), such that the general functions of the undertaking can be used by as many people as possible, regardless of disability. (Equality and Anti-Discrimination Act, 2017, §17).

However, in a report to the UN, the Equality and Anti-Discrimination Ombud claims that in Norway it is too easy for companies to say that accommodation will entail a disproportionate burden, and that this constitutes a violation of the CRPD. Furthermore, the Ombud points out that many persons with disabilities need forms of accommodation that go beyond universal design and recommends expanding the Norwegian legislation with a duty to «most suitable accommodation in all areas of society» (Likestillings- og diskrimineringsombudet, 2015, p. 54–58, my translation). Lid is also critical of the definition of universal design in Norwegian legislation. Pointing out that the definition in the CRPD is more comprehensive, she writes: «In the Norwegian context, there is a danger that universal design is so closely linked to physical conditions that social, political, economic and cultural conditions that can also provide barriers to disability are overlooked» (Lid, 2013, p. 31).

Several examples have illustrated how intertwined physical barriers can be with social practices, such as that accessibility may depend on bus drivers stopping in the right place. At this point, we turn to barriers that are primarily created through social practices.

Social barriers

Public space

Bromley et al. found that

a large part of the adverse ‘experience’ of being a wheelchair user is the reactions experienced on a daily basis from the able-bodied. Feelings of being stared at and being made to feel out of place lead to a strong sense of discomfort and insecurity. (Bromley, Matthews, & Thomas, 2007, p. 239)

Thus, stares from the so-called able-bodied may be considered a barrier in itself which may raise the threshold for getting out of the house. A barrier to sharing concert experiences with friends or a partner arises when organizers – as part of their accommodation – place all wheelchair using audience members in one area (Taub et al., 2009, p. 205).

Some people with intellectual disability are frustrated that store staff or public employees may speak loudly and slowly to them, as if they were children (Welsby & Horsfall, 2011, p. 804). Others describe that their access to participation is weakened when people use terms they do not understand and give them too little time to understand what is being said (see Nind & Seale, 2009, p. 280).

Ordinary background noise can make it difficult for students with autism to study in study halls and libraries. Noise and crowding in bars and clubs can make it impossible for them to participate in social contexts such as freshman weeks or going out after lectures (Madriaga, 2010, pp. 42–46). People with hearing loss are also excluded by noise: When many people speak at the same time, it may be impossible for them to participate, even using a hearing aid (Løvgren, 2009, p. 31).

School and studies

ICT creates new opportunities for facilitation in schools. However, schools may lack the necessary competence to use ICT-based technical aids, and they may have little focus on individual accommodations (Söderström, 2010, p. 37). Children who receive a great deal of supplementary tutoring outside class, may experience that their teachers forget to inform them about school trips and other events (Wendelborg, 2010, p. 34). Schools may fail to include pupils with intellectual disability in class and school councils as well as in the decision-making processes around their individual education plan (IEP); on the other hand, teachers may place so much emphasis on self-determination that the educational offerings degenerate to what may be termed what-would-you-like-to-do-today practices (Sagen & Ytterhus, 2014, pp. 349–350).

Some people with dyslexia describe that the school system has created a perception both in themselves and others that they have a poor intellect or lack commitment. The focus of the supplementary tutoring may have been reading and writing, not practical coping strategies. Some describe that to avoid the work and questions they could not cope with the solution was to behave disruptively in class or play truant. Eventually they gave up (Macdonald, 2009, pp. 353–355).

In higher education, transcribing or digitizing the curriculum may take so long that it hinders students with visual impairment or dyslexia in following the program. Students with

visual impairment may experience that inaccessible literature becomes the biggest barrier (Soorenian, 2014, p. 49; Fjeldvik, 2007, p. 72). Students with mental illness may receive very little information from their university about the possibilities for accommodation and have to find out themselves what they are entitled to. Furthermore, accommodations require disclosing their mental illness, which in turn may expose them to stigma (Panting & Kelly, 2007, pp. 64–66; Soorenian, 2014, pp. 46–48). Accommodations that require the active participation from others may be a struggle: «Kari», who is dependent on hearing aids, had to stand in front of her class every day and argue with lecturers before they – perhaps – agreed to use the microphone she needed to hear the lecture. In the end, she gave up and just studied at home (Magnus & Tøssebro, 2014, p. 327).

Work

Getting necessary workplace accommodations may be a struggle because employers lack knowledge about disabilities and the right to accommodation is too vaguely formulated in the legislation (Wilson-Kovacs, Ryan, Haslam & Rabinovich, 2008, pp. 711–712). Employers may also think that accommodations will require a lot of effort and that they lack the capacity to deal with it, or they may not be willing to spend time on it (Krogh, 2008, p. 79, 90).

Some employees with visual impairment convey that the ICT-based aids and software they need are often incompatible with their companies' computer systems (Krogh, 2008, pp. 84–96; Fjeldvik, 2007, p. 103). Unclear division of responsibilities between IT departments, HR managers and external suppliers may lead to them having to deal with compatibility and operational problems themselves, and perhaps being perceived as inefficient or troublesome to boot (Fjeldvik, 2007, pp. 103–105).

For people with dyslexia, the risk of being asked to fill out forms during the job interview may be a barrier to applying for a job. As employees, they may spend a lot of time and energy dealing with negative perceptions of dyslexia: One strategy is to try to show that they are intelligent before colleagues realize that they have dyslexia (Macdonald, 2009, pp. 356–358). Workers with intellectual disability in sheltered employment may experience that these settings offer little opportunity for advancement. The work itself can be boring, and if they are among the most productive employees, management may discourage them from applying to other jobs (Welsby & Horsfall, 2011, pp. 801–802).

Managers may have too little knowledge about autism to provide appropriate follow-up: One worker with autism describes that being interrupted in tasks or receiving multiple instructions hinders him at work (Aylott, Philips, & McLimens, 2008, pp. 35–37).

Leisure activities

Lack of suitable and accessible transport may also hinder participation in leisure activities. The greater the support need, the more transport and location constraints may impact on the participation of persons with disabilities (Darcy, Lock & Taylor, 2017, p. 34). Other people underestimating one's competence may also be a barrier to participation, as when «Silje», an experienced scout leader with cerebral palsy, experienced that both tasks and responsibilities were assigned to younger and less experienced scout leaders (Løvgren, 2009, p. 33–36).

Crowding may also weaken the accessibility of social contexts for people with physical disabilities. For instance, «Linda» describes that being at parties feels unsafe. With limited physical space, and people running in and out, she is afraid of being pushed over accidentally and breaking something and rarely goes to parties (Taub et al., 2009, p. 206).

Persons with physical disabilities may feel unwelcome at the gym – they are stared at, and others may become impatient when they use more time to get on and off gym equipment. Some barriers arise because instructors lack knowledge about unusual bodies. They may encourage people with disabilities to ignore pain, invalidating their objections and self-knowledge that when it comes to their body, pain is a danger signal (Richardson, Smith, & Papathomas, 2016, pp. 1953–1955; Richardson et al., 2017, pp. 283–286).

Some children with intellectual disability and their parents note that sports organizations often lack the will and ability to accommodate, and that other participants lack an understanding of their limitations and strengths. The result is that they remain on the bench or have to practice with groups where they are not challenged enough (Darcy & Dowse, 2013, p. 399–401). A barrier that youths with autism often experience is that ordinary sports and leisure activities are organized in ways that are too unstructured and unpredictable for them to be able to participate (Brewster & Coleyshaw, 2010, p. 289).

Receiving support and services

In transitions to education or work, young adults with disabilities may experience lack of cooperation between support agencies, and that managing the services one receives takes time and energy away from studies and work (Legard, 2013, p. 23–24). Sometimes agencies can be perceived as deceitful. A young man with a physical disability waited four months to hear whether he was accepted for one of the internships that he and his case officer at the labour and welfare administration had looked at. When he finally got in touch with her, it turned out she had not sent the applications. Without involving him, she had just decided that he ‘would not be able to do those jobs anyway’ (Bakke, 2012, p. 75).

The experiences of children with cerebral palsy in the care of the Norwegian child welfare services suggest that parts of these services not only lack competence in relation to maltreatment in combination with disability, but also an understanding of the importance of such combined competence. The consequences may be that children with disabilities do not receive necessary accommodations and are met with unrealistic expectations (Gundersen, Farstad, & Solberg, 2011, pp. 112–114). Parents of children with disabilities describe that, failing to take the family’s total situation into account, professionals may have little sympathy for parents’ need to occasionally prioritize other concerns over the professionally derived ones (Goddard, Lehr & Lapadat, 2000, pp. 282–283). Parents of adults with intellectual disability may experience a lack of continuity in support services: Some describe how new, overconfident professionals are constantly arriving on the scene and initiating new measures, but then quit their job to move on to new challenges. In practice, the responsibility reverts to the parents each time the support collapses. Support may also collapse because of conflicting perceptions between the involved service agencies. In one case, the labour and welfare administration recommended providing close follow-up in order to help a young man with intellectual disability get to work in the mornings. However, the philosophy of the staff of the group home where he lived, was that he had to learn to manage by himself and learn through the consequences of his actions. He lost his job (Thuve, 2010, pp. 46–47). The way support services for persons with intellectual disability are organized may in itself increase the risk of them being exposed to violence: In their study, Gundersen, Madsen, and Winsvoll found that «violence is facilitated by the way services are organized, through lack of routines and guidelines for preventing violence, and failure in dealing with violence and abuse when such incidents are reported» (2014, p. 53, 140, my translation). On the other hand, routines implemented to protect residents against abuse may be obstacles to privacy, sexuality, and intimacy with significant others, for example through staff repeatedly coming

into the apartment to check on them when they have visitors (Hollomotz, 2008, p. 94-95). People with mental illness may experience pressure in assessments of decision-making capacity (McDaid & Delaney, 2011, pp. 737–738). In the Norwegian Mental Health Care Act, lack of decision-making capacity is one of the conditions for implementing involuntary mental health care (Psykisk helsevernloven, 1999, §3-3). The criteria of decision-making capacity are understanding information, linking it to one's own situation, understanding the consequences of different alternatives, weighing them against each other, and expressing a choice (Helsedirektoratet, 2015, p. 77). In an Irish study, people with mental illness point to the influence that social and environmental factors may have on a person's capacity to make mental healthcare decisions (McDaid & Delaney, 2011, p. 740). For instance:

Participants highlighted how the introduction of medication into a person's system, the available treatment options, the accessibility of information and the speed of the process can hinder their capacity. They also described how social factors including the trustworthiness of the information-provider and the manner of relating to the individual can have an impact (McDaid & Delaney, 2011, p. 740).

This highlights the importance of healthcare and social professionals being willing to look critically at their own role and how their own behavior may influence the situation and thus also the clinical picture they will be basing their assessment on. In the same study, persons with mental illness describe professionals behaving disrespectfully or aggressively towards them, and then, if they have responded by becoming distressed or angry, using this to justify involuntary mental health care (McDaid & Delaney, 2011, p. 739). Another example of the definitional power of professionals is when persons with intellectual disability describe being placed in behavior management classes after becoming frustrated or losing their temper, even if they had good reason to (Welsby & Horsfall, 2011, pp. 803–804).

If clients, service users or patients depend on being supported in daily communication, they also become dependent on staff being allocated enough time to provide such support. If time schedules are too tight, this may affect the staffs' ability to develop the necessary partnering expertise skills, or opportunity to use them (Shaw, Leyshon & Liu, 2007, p. 264). A type of barrier persons with autism may experience is that their support staff lack the necessary skills to communicate well with them (Aylott et al., 2008, p. 34).

How may healthcare and social workers contribute?

Nine suggestions

Avoid creating barriers yourself

The abovementioned examples illustrate that the way services are provided may create barriers, as when the case officer decided that her client 'would not be able to do those jobs anyway' and refrained from forwarding the applications. Her client might not have been able to do these jobs. The problem is that she made the decision without informing or involving him, and that waiting four months for answers to applications that never were sent cannot be termed accessibility. In the example from child welfare services, it seems the services not only lacked competence related to disability, but also an understanding of why lacking such competence should be a problem. Understanding when one's own professional competence is insufficient, and either enhancing it or involving others with the necessary competence, is an essential component in justifiable services. In this case, the children with disabilities were treated as if they were children without disabilities. This may constitute indirect discrimina-

tion, meaning policies or forms of treatment that present as neutral because they apply to everyone, but disadvantage some groups, placing them in a worse position than others. The same applies in the example where persons with autism report that staff lack the skills to communicate well with them. A first suggestion to healthcare and social workers who wish to contribute to dismantling disabling barriers may thus be: *Take responsibility for shortcomings in your own competence.*

To discover the gaps in their own competence, healthcare and social workers may need to obtain feedback on their own actions and performance. As Aarre writes: «We can never grasp the invaluable outside perspective by ourselves. Anyone who does not systematically listen to what patients and other staff members think will ... rob themselves of valuable knowledge» (2010, p. 123, my translation). Traditionally, disability has been seen as an individual feature (NOU 2001: 22, p. 7). Both cultural and professional traditions may contribute to making it seem 'natural' that it is the persons with disabilities who must develop and adapt, while the environment is taken for granted – or, as Tøssebro (2010, p. 16) writes, «goes free». Healthcare and social workers are very much part of the environment of their clients, service users, or patients. Discovering in what ways they may be contributing to a person's disablement, may require taking a critical stance towards their own assumptions. In turn, this may require access to new perspectives on what they are familiar with and believe that they know. A prerequisite for more equal services may thus be that healthcare and social workers allow themselves to be challenged – by clients, service users, patients, families, each other, and through reflection over salient situations and events – and use this to develop their assumptions further. Thus, the second and third suggestions to service providers become: *Be critical of your own assumptions. Evaluate your roles and practices also from the perspective of others.*

The examples from support services to persons with intellectual disability illustrate the weakness of designing services based on medical diagnoses or other ways of defining group categories. Routines that may be necessary to protect some service users from abuse may become unduly intrusive on other service users. This also illustrates that services that aim to promote equality may require healthcare and social workers to develop sufficiently specific and individualized knowledge of service users' needs, in collaboration with them. Simply, such knowledge must also build on how the service users themselves understand their situation. It cannot be taken for granted that clients, service users or patients perceive any of their difficulties in daily life as being a result of interactions with external barriers. To offer them such a perspective would be to align with the fundamental values of the CRPD, but they may be unreceptive. To insist that a given situation should be understood a certain way, may in itself represent a barrier. A fourth suggestion is: *Create a sufficiently specific knowledge base together with clients, service users and patients; do not base measures on knowledge related to diagnosis or category alone.*

The examples of service users' experiences suggest that lack of cooperation between agencies may be disabling – as when clients, service users or patients spend so much time and energy managing the services they receive, that it affects their ability to work or study – or when an employee with intellectual disability loses his job because the labour and welfare administration and group home staff prioritize different goals for him. Reducing such barriers requires collaboration: involved agencies must be able to distribute tasks among themselves to achieve common, agreed goals, and implement them in a coordinated, rational way (Helse- og omsorgsdepartementet, 2009, p. 13). Such implementation can only happen if all involved agencies (and healthcare and social workers) see the services they provide as part of a whole, and take responsibility for cross-agency interaction. The fifth suggestion thus becomes: *Take responsibility for ensuring that the services you provide are adapted to and coordinated with the services from other agencies.*

Help dismantle barriers on other arenas

Healthcare and social workers are parts of larger organizations. In addition to avoiding creating barriers themselves, they may try to inspire and motivate colleagues to act in less disabling ways towards clients, service users, or patients. This may also involve influencing the organization they are part of to dismantle physical and social barriers. Sixth suggestion: *Try to influence your organization and colleagues to dismantle disabling barriers in physical premises and social practices.*

Understanding disability as a relationship and not as an individual feature offers two complementary approaches to any situation where persons with disabilities fall short: first, strengthening the person's capacity to fulfil the demands of the environment, and secondly, adapting the demands of the environment (Lid, 2013, p. 27). Many healthcare and social workers will be involved in implementing measures related to persons with disabilities. Following the above, they will need to know what parts of the measures are aimed at strengthening the person's capacity, what parts are aimed at dismantling disabling barriers, and what the fundamental difference is. A smaller number of healthcare and social workers will be involved in developing measures in collaboration with the person, for example in roles as coordinator for individual plans or primary contact for service users. This may also involve engaging in matters of accessibility and inclusion on arenas other than the one where they work themselves. This article provides a great deal of examples of potential barriers. Some are mostly relevant for specific disabilities, while others are more general. They do not provide an 'answer sheet' on what may constitute disabling barriers for a given person, but they offer healthcare and social workers suggestions for aspects to focus on together with the person, in exploring what environmental conditions may inhibit and promote his or her participation on various arenas. Once barriers are identified, the question becomes what to do and who does what. What may constitute an appropriate division of tasks will depend both on the healthcare and social workers' and person's respective resources and strengths, the person's wishes, to what extent arenas are obliged to be universally designed or offer individual accommodation, and who is responsible for this. Further questions are to what extent sufficient levels of receptivity exists or may be created in these arenas, what documentation of barriers is necessary, and to whom such documentation must be presented to bring about change. A key concern is that the person should experience increased accessibility without the process itself becoming an unbearable burden. For healthcare and social workers who wish to help increase the level of accessibility in society in general, a goal may become to document barriers and spread the knowledge about them generally. The seventh and eighth suggestion become: *Work alongside clients, service users and patients to reduce barriers also on other relevant arenas for participation. Take initiatives to document barriers based on the experiences of clients, service users and patients.*

Support persons with disabilities who face barriers that cannot be dismantled

Seeing disability as a relationship between individual and environment is a useful way to understand situations where clients, service users or patients with disabilities struggle to participate fully and effectively. It shifts our focus to aspects of the environment which may be changed to enhance their participation. But not all solutions are possible to implement universally (Lid 2013, pp. 171–173). Tøssebro writes: «dismantling a barrier for some people may create a new one for others. A curb is an obstacle for wheelchair users but helps the blind to orient themselves. Some people need a lot of light to see contrasts, others are light sensitive» (2010, p. 22, my translation). New forms of orientation assistance can be created, but how are public spaces created with both a lot and little light? When store staff

and public employees perceive that they are facing a person with intellectual disability – how are they to know if he or she is among those who need them to speak slowly and clearly, or among those who will find it offensive? They may ask – but not without signaling that they understand or assume that the person has intellectual disability. That may in itself be perceived as offensive. There are limits to how much knowledge employers, sports coaches, lecturers, or passers-by can have about different types of disability. There are limits to what they can be obligated to change, or even with the best of will may be able to change. Wherever the line is drawn on what constitutes an ‘unreasonable burden’, it will be drawn somewhere. No matter what resources persons with disabilities have at their disposal, there will be limits to their capacity to argue their case.

In sum, this means that not all barriers can be eliminated or reduced. If nothing else, then because such conditions must be experienced, identified, and discussed with those who are in a position to change them before they can be changed. Any path to a more accessible and inclusive society will necessarily be paved with encounters with disabling barriers.

To the extent barriers are unavoidable, healthcare and social workers may support persons with disabilities before, during and after facing barriers. Such support may take many forms. Perhaps it feels most ‘natural’ to encourage the person to ‘accept the inevitable’, ‘rise above it’, to ‘understand’. But the experience of facing barriers may for some feel like falling short of expectations, whether these expectations are made explicit, or are built into physical design or social practices. If such ‘failings’ are not explicitly attributed to the environment, in all probability, the person will attribute them to his or her own body or mind. Thus, many persons with disabilities find it very liberating to become aware of the role that environments play in their disablement (Shakespeare, 2013, p. 13). Such processes of awareness-raising and self-organization among people with disabilities have played a crucial role on the long road to the present-day focus on accessibility – ever since the activists in the British Union of the Physically Impaired Against Segregation first described disability as a burden imposed on top of their impairments (UPIAS, 1976, p. 3).

Terms such as activism and self-organization may be associated more with the realm of politics than with healthcare or social work. But healthcare and social workers must also be able to support clients, service users and patients in such processes. Following Hammell, healthcare and social workers will either ‘play an active role in maintaining and perpetuating disabling environments, or an active role in changing them. Both roles are political; there is no neutral stance’ (2006, p. 142). Thus, the ninth and final suggestion is: *Support awareness, self-organization, and resistance to barriers among clients, service users and patients with disabilities.*

Main principles

Avoid creating barriers yourself. Promote the dismantling of physical and socially created barriers in your organization and on other relevant arenas for participation. Support clients, service users and patients with disabilities to self-organize and actively resist barriers.

Nine suggestions

1. *Take responsibility for shortcomings in your own competence.*
2. *Be critical of your own assumptions.*
3. *Evaluate your roles and practices also from the perspective of others.*
4. *Create a sufficiently specific knowledge base together with clients, service users and patients; do not base measures on knowledge related to diagnosis or category alone.*
5. *Take responsibility for ensuring that the services you provide are adapted to and coordinated with the services from other agencies.*
6. *Try to influence your organization and colleagues to dismantle disabling barriers in physical premises and social practices.*
7. *Work alongside clients, service users and patients to dismantle barriers also on other relevant arenas for participation.*
8. *Take initiatives to document barriers based on the experiences of clients, service users and patients.*
9. *Support awareness, self-organization, and resistance to barriers among clients, service users and patients with disabilities.*

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