

ANALYSING THE DEFINITION OF DISABILITY IN THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: IS IT REALLY BASED ON A 'SOCIAL MODEL' APPROACH?

KATERINA KAZOU*

ABSTRACT

This article challenges the generally accepted view that the UN Convention on the Rights of Persons with Disabilities 2006 (CRPD) is based on the 'social model of disability'. The 'social model' understands disability as a social situation, and particularly a form of social oppression imposed on people with impairments, which is caused by social and environmental barriers that exclude them from participating in society and which is entirely distinguished from their individual impairment. The article argues that the definition of disability in the CRPD is closer to the definition provided in WHO's International Classification of Functioning, Disability and Health (ICF). The ICF understands disability as the multi-dimensional and interactive experience of a wide range of difficulties in functioning; in particular, these difficulties include impairments, limitations in performing activities and restrictions in participating in life situations, and arise out of the complex interaction between health conditions, personal factors and barriers in the physical and social environment. Associating the CRPD with the ICF rather than the 'social model' might have positive implications for its implementation, as it can avoid the criticism faced by the 'social model' for its limitations, especially for considering impairment as being entirely irrelevant to the experience of disability, and therefore governments and policy makers might be less sceptical towards the CRPD and more willing to engage with it. At the same time, the valuable insights of the 'social model' regarding the disabling effect of social and environmental barriers can be retained, as the ICF recognises this too, but without ignoring the relevance of impairment to the experience of disability or minimising the health needs of persons with disabilities.

I. INTRODUCTION

The UN Convention on the Rights of Persons with Disabilities (CRPD)¹ is one of the nine core international human rights treaties and, as of July 2017, 160 States have signed it and 174 have ratified it.² It is the first legally binding instrument on the issue of disability³ and its purpose is to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with

* Katerina Kazou, PhD Candidate and University Tutor, Leicester Law School, University of Leicester.

¹ United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted by the General Assembly on 13 December 2006, UN Doc. A/RES/61/106, 24 January 2007 (entered into force 3 May 2008).

² See the UN Enable website:

<<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>> accessed 31 July 2017.

³ Previous international 'soft law' instruments on the issue of disability include the *Declaration on the Rights of Mentally Retarded Persons 1971*, the *Declaration on the Rights of Disabled Persons 1975*, the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health 1991* and the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities 1993*.

disabilities, and to promote respect for their inherent dignity'.⁴ The CRPD applies to all persons with disabilities, including those with mental,⁵ or psychosocial,⁶ disabilities.⁷

This article considers the definition of disability set out in the CRPD, and disputes the generally accepted view⁸ that this is based on the 'social model of disability'. This term refers to the best known social approach to disability, developed in Britain during the 1970s and 1980s by disabled people themselves. The British 'social model' approach understands disability as a socially created problem, caused by social and environmental barriers that exclude people with impairments from participating in society, and which is entirely distinguished from their individual impairment.

The article begins with an examination in Part II of the British 'social model' approach to disability, and Part III examines the definition of disability provided in WHO's International Classification of Functioning, Disability and Health (ICF).⁹ The ICF describes disability as the multi-dimensional and interactive experience of a wide range of difficulties in functioning; in particular, these difficulties include impairments, limitations in performing activities and restrictions in participating in life situations, and arise out of the complex interaction between health conditions, personal factors and barriers in the physical and social environment. In light of this, Part IV considers the CRPD definition of disability in its Preamble:

[D]isability is an evolving concept and ... 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.¹⁰

It is argued that the CRPD defines disability in a way which is closer to the ICF conceptualisation, rather than adopting the British 'social model' approach. Although the connection between the CRPD and the ICF has been noted before,¹¹ this article provides in addition a full explanation and analysis of this connection, also in contrast to the British 'social model' approach.

II. THE BRITISH 'SOCIAL MODEL' OF DISABILITY

The purpose of this Part is to identify what is meant by, and how disability is understood under, the 'social model', in order to determine in Part IV whether the CRPD defines disability in accordance with this approach. Although still evolving, the unique features that characterise the 'social model of disability' are found in a

⁴ CRPD, Art 1.

⁵ The term used in the CRPD, taken to refer to the experience of mental health difficulties.

⁶ The term preferred by some, especially - but not only - service users, over 'mental disabilities': see for example World Network of Users and Survivors of Psychiatry, 'Psychosocial Disability' <<http://www.wnusp.net/index.php/crpd.html>> accessed 31 July 2017; World Network of Users and Survivors of Psychiatry, 'Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities' (2008) 9 <http://www.wnusp.net/documents/WNUSP_CRPD_Manual.pdf> accessed 31 July 2017.

⁷ CRPD, Art 1.

⁸ For examples, see below pp 39-40.

⁹ World Health Organisation (WHO), *International Classification of Functioning, Disability and Health (ICF)*, endorsed in May 2001, Res. WHA 54.21 of the 54th World Health Assembly (WHO 2001).

¹⁰ CRPD, PmbI, para (e).

¹¹ See below p 37.

document called 'Fundamental Principles of Disability',¹² published by the Union of the Physically Impaired against Segregation (UPIAS), and the work of Michael Oliver.¹³ Therefore, focus will be placed on how disability is described in the UPIAS document, and Oliver's conceptualisation of the 'social model'.

As stated above, the term 'social model of disability' refers to the British social approach to disability. The various social approaches that have been developed reject the idea that disability is simply a medical problem arising from individual impairment, and draw attention to environment's and society's role in creating disability. The British approach in particular, as will be seen below, denies any causal link between impairment and disability and suggests instead that disability is created solely within society.

Prior to the late 1960s and 1970s, disability, viewed from a medical perspective, was regarded as the result of individual impairment which requires medical care, rehabilitation and individual adjustment. During that period, however, a social approach to understanding the nature and consequences of disability emerged, as disabled activists and organisations controlled and run by disabled people drew attention to their social and economic exclusion and began campaigning for social changes to improve their lives. The previously dominant medical and individual understandings of disability were challenged, and focus was placed instead on the impact of social and environmental barriers and the discrimination and disadvantage experienced by people with impairments.

The social approach was further developed, as disabled people's political activism led to a growing interest in the issue of disability within the academy, especially within sociology. Although disability was traditionally studied within the sub-field of medical sociology, and particularly the sociology of chronic illness and disability,¹⁴ the new discipline 'disability studies' that was developed in the 1980s and 1990s began approaching disability from a social perspective.¹⁵

The best known social approach has been developed in Britain and is known as the 'social model of disability'; however, social understandings of disability have been advanced by disabled activists and disability studies scholars in several countries. As Tom Shakespeare states in *Disability Rights and Wrongs*, there is a 'family of social-contextual approaches to disability',¹⁶ including, besides the British approach, the

¹² The Union of the Physically Impaired Against Segregation and the Disability Alliance, *Fundamental Principles of Disability: Being a Summary of the Discussion Held on 22nd November, 1975 and Containing Commentaries from Each Organisation* (UPIAS 1976) <<http://disability-studies.leeds.ac.uk/files/library/UPIAS-fundamental-principles.pdf>> accessed 31 July 2017.

¹³ Michael Oliver, *The Politics of Disablement* (Macmillan 1990); Michael Oliver, *Understanding Disability: From Theory to Practice* (Palgrave 1996).

¹⁴ For a review of the sociological approaches to chronic illness and disability, see Colin Barnes and Geof Mercer, *Exploring Disability* (2nd edn, Polity Press 2010) 43-70.

¹⁵ Note that, although referred to above as 'discipline', disability studies are best described as interdisciplinary. On the development of disability studies, see Colin Barnes, Mike Oliver and Len Barton, 'Introduction' in Colin Barnes, Mike Oliver and Len Barton (eds), *Disability Studies Today* (Polity Press 2002) 1-15; Rannveig Traustadóttir, 'Disability Studies, the Social Model and Legal Developments' in Oddný Arnardóttir and Gerard Quinn (eds), *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijhoff Publishers 2009) 4-7.

¹⁶ Tom Shakespeare, *Disability Rights and Wrongs* (Routledge 2006) 9.

Nordic 'relational' understanding and the North America 'minority group' approach.¹⁷ Nonetheless, since the British 'social model' approach has been the most influential, this term is often associated with the many social understandings of disability. This however can be misleading because, despite sharing many similarities, the various social approaches also have unique characteristics. What distinguishes the British 'social model' is the radical idea that the cause of disability is found exclusively within society, whereas the role of impairment in creating disability is entirely denied.

This strong view is only adopted by the British 'social model', and it is therefore important to emphasise that it is only the British approach that makes the distinction between impairment and disability; thus, a social approach to disability does not necessarily rely on that distinction.

Union of the Physically Impaired against Segregation (UPIAS)

The British social approach was developed by disabled activists such as Vic Finkelstein¹⁸ and disability studies scholars such as Michael Oliver¹⁹ and Colin Barnes,²⁰ based on a materialist understanding of disability.²¹ The term and conceptualisation of the 'social model of disability' was conceived by Oliver in 1981; however, the basic ideas of this new understanding, most importantly as regards the cause of disability, were introduced in 1976, in UPIAS's 'Fundamental Principles of Disability'. UPIAS was a disabled people's organisation, created in the 1970s, and among its leaders were Paul Hunt and Vic Finkelstein. Disability is described in the document as follows:

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called 'disability', of people with such impairment. Thus we define impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body; 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

¹⁷ The 'relational' approach understands disability as a relationship between the individual and the environment, whereas the 'minority group' approach focuses on the discrimination against persons with disabilities and regards civil rights legislation as the appropriate response: See generally Shakespeare, *Disability Rights and Wrongs* (n 16) 23-26. On the 'relational' approach see more specifically Jan Tøssebro and Anna Kittelsaa (eds), *Exploring the Living Conditions of Disabled People* (Studentlitteratur 2004). On the 'minority group' approach see more specifically Harlan Hahn, 'The Politics of Physical Differences: Disability and Discrimination' (1988) 44 *Journal of Social Issues* 39; Harlan Hahn, 'Antidiscrimination Laws and Social Research on Disability: The Minority Group Perspective' (1996) 14 *Behavioral Sciences and the Law* 41.

¹⁸ Victor Finkelstein, *Attitudes and Disabled People: Issues for Discussion* (World Rehabilitation Fund 1980).

¹⁹ Oliver, *The Politics of Disablement* (n 13); Oliver, *Understanding Disability: From Theory to Practice* (n 13).

²⁰ Colin Barnes, *Disabled People in Britain and Discrimination: A Case for Anti-Discrimination Legislation* (Hurst & Company 1991).

²¹ According to this understanding, disability is linked to the rise of capitalism and particularly the capitalist mode of production: For an overview of materialist accounts of disability, see Colin Barnes, Geof Mercer and Tom Shakespeare, *Exploring Disability: A Sociological Introduction* (Polity Press 1999) 83-86. See also Brendan Gleeson, 'Disability Studies: A Historical Materialist View' (1997) 12 *Disability & Society* 179; Mark Priestley, 'Constructions and Creations: Idealism, Materialism and Disability Theory' (1998) 13 *Disability & Society* 75.

excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression.²²

As evident in the above statement, UPIAS adopts a new understanding of disability, which has two main characteristics. First, a distinction is made between impairment and disability, which has been crucial to the British 'social model' of disability. It can be said in particular that this distinction is relied upon to argue that disability is not a problem of functional limitations, but one of social and economic structures. Second, disability is viewed as social oppression, which points to the relationship between those with impairments and the rest of society. These characteristics will now be examined, starting with the way in which impairment and disability are separated in the UPIAS document.

As a starting point, it can be argued that there are two different ways of distinguishing between impairment and disability. First, it might be in terms of their different meaning. By including in the document definitions of impairment and disability, UPIAS highlights that these terms are not synonymous: Impairment is defined as 'lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body', whereas disability is defined as 'disadvantage or restriction of activity'.²³ It is therefore clear that impairment refers to a problem with the body, whereas disability refers to something else, namely a difficulty in performing activities.

UPIAS however goes further than that; besides separating impairment from disability in the sense that they do not share the same definition, the two terms are also distinguished in terms of causality. Thus, the distinction between impairment and disability also relates to their relationship, or rather the lack thereof, and specifically the absence of a causal link between them. Not only is it suggested that disability *is* not impairment, but also that disability is not *caused* by impairment. The lack of a connection between impairment and disability is evident in the UPIAS document, as it is explicitly stated that disability is 'caused by a contemporary social organisation which takes no or little account of people who have physical impairments'.²⁴ It is therefore clear that, according to the UPIAS understanding, disability is socially imposed on people with impairments. The cause of disability, which is defined as the restriction of activity of people with impairments, is not impairment, but society's failure to include them in social activities. Importantly, it is the distinction in *that* sense that constitutes, as mentioned above, the unique feature of the British social model of disability.

The second characteristic of disability found in the UPIAS document is its understanding as the social oppression of people with impairments. UPIAS views disability in terms of social relations and refers in particular to the relationship between two groups of people. However, this relationship is viewed as only having negative aspects and it is therefore argued that people with impairments are subject to social oppression by those without impairments. Thus, having being 'disconnected' from impairment, disability is understood as the disadvantage experienced by people with impairments due to their social exclusion; since it is society that creates this disadvantage, disability is seen as a form of social oppression.

²² UPIAS, *Fundamental Principles of Disability* (n 12) 20.

²³ *ibid.*

²⁴ *ibid.*

The UPIAS understanding of disability and impairment was subsequently adopted by other disabled people's organisations, including Disabled People's International (DPI), an international body of national organisations of disabled people, and the British Council of Organisations of Disabled People (BCODP), the umbrella body for disabled people's organisations in the United Kingdom. It is important to note at this point that, although the definition of impairment initially concerned only physical conditions, it later included all types of impairment.²⁵ This is evident in the definitions adopted by DPI in 1982, which also endorsed the separation of impairment and disability:

Impairment is the functional limitation within the individual caused by physical, mental or sensory impairment.

Disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers.²⁶

Impairment – physical, as well as mental or sensory - is therefore distinguished from disability. Although both are defined as limitations, the former is described in medical terms whereas the latter is described in social terms. Furthermore, no causal link exists between them, since disability does not result from impairment but is rather created by barriers to participation in society. Interestingly, disability as defined by the DPI may be experienced even by individuals without impairments. However, as Bickenbach and others have noted, this seems to suggest that anyone who is excluded from participation in society may be regarded as disabled.²⁷

Conceptualisation from Oliver

Influenced by the ideas found in the UPIAS document, Michael Oliver decided to develop a framework for the distinction between impairment and disability. To that end, he conceptualised in 1983 the 'social model of disability' and distinguished it from the 'individual model of disability'.²⁸ The latter is underpinned by the idea of 'personal tragedy', whereas the former is based on the theory of 'social oppression'.²⁹

It should be noted at this point that medical approaches to disability are usually referred to as the 'medical model' of disability. According to this approach, disability is considered an individual deficit and is seen from a biomedical perspective as the outcome of impairment. It is understood in terms of functional limitations which require medical solutions; accordingly, the appropriate responses include prevention, cure, treatment and care. The 'social' model is more commonly contrasted to this 'medical' model of disability. Nevertheless, Oliver avoids the use of that term and rather refers to the 'individual' model. His view, as stated in *Understanding Disability*, is that 'there is no such thing as the medical model of disability'; there is instead medicalisation,³⁰

²⁵ Colin Barnes, 'Understanding the Social Model of Disability: Past, Present and Future' in Nick Watson, Alan Roulestone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge 2012) 14.

²⁶ Disabled Peoples' International (DPI), *Proceedings of the First World Class Congress* (Disabled Peoples' International 1982).

²⁷ Jerome Bickenbach and others, 'Models of Disablement, Universalism and the International Classification of Impairments, Disabilities and Handicaps' (1999) 48 *Social Science & Medicine* 1173, 1176.

²⁸ Oliver, *Understanding Disability* (n 13) 30.

²⁹ Oliver, *The Politics of Disablement* (n 13) 1.

³⁰ The 'medicalisation' of disability refers to the dominance of medical explanations for disability and reliance on medical expertise regarding that issue. It is linked to the rise and growth of medicine and

which, albeit significant, is merely an aspect of the individual model.³¹ He similarly states in *The Politics of Disablement* that individualism is the 'core' ideology that determines how disability is understood, whereas medicalisation is a 'peripheral' ideology which makes disability 'a particular kind of problem'.³²

Accordinging therefore to Oliver's conceptualisation, disability can be viewed either from an 'individual' or from a 'social' perspective. The individual model views the problem as located in the individual and caused by functional limitations, whereas the social model views it as located within society and caused by society's failure to address the needs of persons with impairments.³³ The 'social model' approach places great emphasis on the 'disabling' environment which excludes people with impairments from participation in society. Disability is therefore understood as the consequence of externally imposed barriers to social inclusion. Finkelstein argues in *Attitudes and Disabled People* that, as long as social barriers to the reintegration of persons with impairments are not removed, disability will continue to exist. Accordingly, social action is required and particularly 'changes in society, changes to the environment, changes in environmental control systems, changes in social roles, and changes in attitudes by people in the community as a whole'.³⁴ Oliver similarly states that the purpose of the social model is to draw attention, not to functional limitations of persons with impairments, but to the economic, environmental and cultural barriers they face, such as inaccessible education systems and transport, discriminatory health services and negative attitudes.³⁵

The 'social model' approach takes the view that economic and social forces create disability, and that consequently the appropriate response for its elimination is the removal of disabling barriers to participation in society. It is based on radical ideas that describe disability in terms of social oppression, and deny any causal link between disability and impairment. It should finally be noted that although it has exercised great influence on disabled people and their organisations, as well as disability studies,³⁶ it has been widely criticised over recent years for its limitations, even within disability studies.³⁷ Consequently, the 'social model' approach is still evolving, although it has

the medical profession, and particularly to the role of medicine as a mechanism for social control. For Oliver's view on medicalisation, see Oliver, *The Politics of Disablement* (n 13) 49-54; Michael Oliver and Colin Barnes, *The New Politics of Disablement* (2nd edn, Palgrave Macmillan 2012) 83-85. See also Barnes and Mercer, *Exploring Disability* (n 14) 59-63.

³¹ Oliver, *Understanding Disability* (n 13) 31.

³² Oliver, *The Politics of Disablement* (n 13) 46, 58.

³³ Oliver, *Understanding Disability* (n 13) 32.

³⁴ Finkelstein (n 18) 22.

³⁵ Mike Oliver, 'The Social Model in Action: If I Had a Hammer' in Colin Barnes and Geof Mercer (eds), *Implementing the Social Model of Disability: Theory and Research* (The Disability Press 2004) 6 <<http://disability-studies.leeds.ac.uk/files/library/Barnes-implementing-the-social-model-chapter-2.pdf>> accessed 31 July 2017.

³⁶ For an overview of the social model's major influences on disability studies and disability policy, see Barnes, 'Understanding the Social Model of Disability: Past, Present and Future' (n 25) 17-21.

³⁷ For an overview of the main criticisms of the social model, see Carol Thomas, 'Rescuing a Social Relational Understanding of Disability' (2004) 6 *Scandinavian Journal of Disability Research* 22, 25-27. Tom Shakespeare summarises the debates around, and makes his own critique of, the social model: see Shakespeare, *Disability Rights and Wrongs* (n 16) 34-50. See also Tom Shakespeare, *Disability Rights and Wrongs Revisited* (2nd edn, Routledge 2014) 21-42. Also, note in particular the criticisms made by feminist writers such as Jenny Morris, Liz Crow and Sally French: see Jenny Morris, *Pride against Prejudice: Transforming Attitudes to Disability* (Women's Press 1991); Liz Crow, 'Including All of Our Lives: Renewing the Social Model of Disability' in Colin Barnes and Geof Mercer (eds) *Exploring*

not abandoned its unique characteristic, namely the idea that disability is caused by social and environmental barriers to inclusion and participation in society, rather than impairment.

The following Part will examine a more balanced - in the sense that it combines medical and social understandings - approach to disability than the British 'social model', found in WHO's International Classification of Functioning, Disability and Health (ICF).³⁸

III. WHO'S INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH (2001)

The purpose of this Part is to identify how disability is understood in the ICF, in order to assess in the following Part the connection between this understanding and the definition of disability in the CRPD.

The ICF is a classificatory instrument for the description of health and health-related states.³⁹ The ICF, as well as its previous version, namely the International Classification of Impairments, Disabilities and Handicaps (ICIDH),⁴⁰ are examples of the significant changes that were brought to international understandings of disability by the development and influence of the social approach to disability. However, although they recognise its social aspect, both ICIDH and ICF conceptualise disability as multi-dimensional and can therefore be considered balanced accounts.

As explained below, disability is described in the ICF not as restriction of ability to perform activities, but as the experience of difficulty at one or more of three levels of human functioning, namely at the body, person, or social level. It is therefore experienced as problems in body function or structure, in executing activities, or in involvement in life situations respectively. Furthermore, these problems arise from the interaction between the underlying health condition and contextual factors, namely features of the physical, social, and attitudinal environment as well as personal attributes.⁴¹ This understanding of disability acknowledges the various factors that are relevant to the experience of people with impairments, and the relationship between these factors. Before considering in more detail the conceptualisation of disability in the ICF, it would be useful first to examine how disability was conceptualised in the ICIDH and how that understanding was influenced by the social approach.

the Divide: Illness and Disability (The Disability Press 1996); Sally French, 'Disability, Impairment or Something in Between?' in John Swain and others (eds), *Disabling Barriers – Enabling Environments* (SAGE 1993).

³⁸ WHO, *ICF* (n 9).

³⁹ The ICF belongs to the WHO's 'family' of international classifications. The other major classification is the ICD-10: WHO, *International Statistical Classification of Diseases and Related Health Problems: Tenth Revision (ICD-10)*, endorsed in May 1990, Res. WHA 43.24 of the 43rd World Health Assembly (WHO 1992). Note the difference between the ICD-10 and the ICF: The ICD-10 provides an etiological framework for the classification, by diagnosis, of diseases, disorders and other health conditions, whereas the ICF provides a framework for the classification of functioning and disability associated with health conditions.

⁴⁰ WHO, *International Classification of Impairments, Disabilities and Handicaps (ICIDH)*, endorsed in May 1976, Res. WHA 29.35 of the 29th World Health Assembly (WHO 1980, rpt in 1993).

⁴¹ For the overview of the ICF, see WHO, *ICF* (n 9) 11. For a short and helpful description of the ICF conception of disability, see WHO and the World Bank, *World Report on Disability* (WHO 2011) 5.

The International Classification of Impairments, Disabilities and Handicaps (ICIDH)

The ICIDH was published for field trial purposes in 1980 and was a classificatory instrument for the 'consequences of disease (as well as of injuries and other disorders) and of their implications for the lives of individuals'.⁴²

There were three main classifications in the ICIDH, namely impairment, which represented 'disturbances at the organ level', disability, which reflected 'disturbances at the level of the person' and handicap, which reflected 'interaction with and adaptation to the individual's surroundings'.⁴³ Specifically, impairment was defined as 'any loss or abnormality of psychological, physiological, or anatomical structure or function',⁴⁴ disability as 'any restriction or lack ... of ability to perform an activity in the manner or within the range considered normal for a human being'⁴⁵ and handicap as 'a disadvantage for a given individual ... that limits or prevents the fulfilment of a role that is normal ... for that individual'.⁴⁶ Regarding the relationship between them, disability was considered the result of impairment and handicap the result of impairment or disability.⁴⁷

The ICIDH therefore distinguishes between impairment, disability and handicap. Interestingly, as Bickenbach and others note, the British 'social model' definition of disability is very similar to the ICIDH definition of handicap.⁴⁸ Both terms refer to the social exclusion and disadvantage experienced by persons with impairments; nevertheless, the ICIDH understands social disadvantage as the consequence of disability, whereas the 'social model' approach understands it as the cause of disability. Thus, whilst the ICIDH recognises three levels of the experience relating to disease or other health conditions, the 'social model' approach only accepts the existence of impairment and disability; the latter is defined not as restriction of activity, but rather as the disadvantage created by social and environmental barriers.

Furthermore, the ICIDH explicitly recognised that people with impairments experience social disadvantage, and the role of social and environmental factors in that experience, and can therefore be considered as a positive step towards the development of a social understanding of disability. As Mike Bury states, those who developed the ICIDH took the view that 'the WHO was moving away from a narrow medical model of health and disease ... to one which recognised the consequences of health-related phenomena'.⁴⁹ The ICIDH drew attention to the social consequences of impairment, and, although it did not entirely adopt the 'social model' approach, it did pose challenges to the medical model of disability.

However, the ICIDH was seen by the proponents of the 'social model' approach as reflecting the ideas of the medical model, because of the relationship between the three categories and particularly the causal link between impairment and disability.⁵⁰

⁴² WHO, *ICIDH* (n 40) 1.

⁴³ *ibid* 14.

⁴⁴ *ibid* 27.

⁴⁵ *ibid* 28.

⁴⁶ *ibid* 29.

⁴⁷ *ibid* 28-29.

⁴⁸ Bickenbach and others (n 27) 1177.

⁴⁹ Mike Bury, 'A Comment on the ICIDH2' (2000) 15 *Disability and Society* 1073, 1073.

⁵⁰ See Finkelstein (n 18); Oliver, *The Politics of Disablement* (n 13).

It seems indeed that the ICIDH failed to recognise that social and environmental barriers may also have disabling effects, and may therefore create disadvantage for people with impairments. The one-way causal connection between impairment, disability and handicap appears problematic, which is why this linear progression was later changed in the ICF. As explained in particular in the foreword to the 1993 reprint, the ICIDH needed to be revised mainly in order to address problems regarding the relationship between the three categories and also to draw more attention to the role of environment in the development of handicap.⁵¹

The International Classification of Functioning, Disability and Health (ICF)

The revised version of the ICIDH, namely the ICF, was published by WHO in 2001. The ICF is 'a multipurpose classification intended to serve various disciplines and different sectors'⁵² and its aim is to offer 'a unified and standard language and framework for the description of health and health-related states'.⁵³ It is now a classification of the 'components of health'; it is no longer concerned, as the ICIDH was, with the 'consequences' of disease.⁵⁴ The problematic aspects of the ICIDH regarding the causes of disability are therefore avoided in the ICF, which rather 'takes a neutral stand with regard to etiology'.⁵⁵

The ICF provides a framework for 'situations with regard to human functioning and its restrictions',⁵⁶ and describes a wide range of experiences, both negative and positive. Importantly, the understanding of disability is changed; whilst in the ICIDH disability was described as restriction of ability to perform activities, it now refers to problems in functioning. In particular, the ICF defines disability as 'an umbrella term for impairments, activity limitations and participation restrictions'.⁵⁷ Thus, as Bickenbach states, disability is viewed as 'parasitical on positive, multidimensional notions of human functioning'.⁵⁸

The ICF identifies three levels of human functioning, namely the body, person, and social level; disability is conceptualised as the experience of difficulty in one or more of them. The concepts that indicate problematic aspects of health are included in the first part of the ICF, which is called 'Functioning and Disability'.⁵⁹ These are in particular 'impairments', which are 'problems in body function or structure'; 'activity limitations', which replace the ICIDH term 'disabilities' and are 'difficulties in executing activities'; and 'participation restrictions', which replace the ICIDH term 'handicaps' and are 'problems in involvement in life situations'.⁶⁰

One significant development in the ICF is the recognition of the multi-dimensional character of disability. The ICF is therefore based on a 'synthesis' of the medical and

⁵¹ WHO, *ICIDH* (n 40) 4.

⁵² WHO, *ICF* (n 9) 5. For a summary of the aims and applications of the ICF, see WHO, *ICF* (n 9) 5, 6.

⁵³ *ibid* 3.

⁵⁴ *ibid* 4.

⁵⁵ *ibid*.

⁵⁶ *ibid* 7.

⁵⁷ *ibid* 213.

⁵⁸ Jerome Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' in Nick Watson, Alan Roulestone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge 2012) 53.

⁵⁹ WHO, *ICF* (n 9) 8.

⁶⁰ *ibid* 10.

social models of disability; it integrates in particular all the aspects of functioning by adopting a 'biopsychosocial' approach.⁶¹ This term is more commonly associated with George Engel, who used it in 1977 when he argued for the need to abandon the traditional biomedical model of disease and advance instead a 'biopsychosocial model'.⁶² In particular, he saw the former as reductionist and therefore claimed that it is insufficient for understanding what causes diseases and how they can be treated. As he stated, it places too much emphasis on biology and 'leaves no room within its framework for the social, psychological, and behavioral dimensions of illness'.⁶³ In adopting this approach, the ICF takes the view that the experience of disability depends on biological, individual and societal factors.

Another significant development in the ICF is that it avoids making any direct causal links between impairment and disability; its conceptualisation is instead interactional. In particular, a person's disability, as well as functioning, 'is conceived as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors'.⁶⁴ Thus, focus is placed on the whole experience associated with a health condition. The ICF therefore departs from the ICIDH linear conceptualisation and suggests that the components of health interact with one another. The contextual factors are described in the second part of the ICF and are personal, which are not classified, and environmental. The environmental factors that are relevant in determining disability are barriers that exist in the physical, social or attitudinal environment and may be individual or societal. Individual factors include settings such as home, workplace and school, whereas societal include organisations and services related to the work environment, community activities, communication and transportation services, and informal social networks as well as laws, regulations, attitudes and ideologies.⁶⁵

As a final point, it should be mentioned that the ICF, in spite of the revision process, has still been subject to considerable criticism.⁶⁶ It is important to emphasise, however, that the ICF does not adopt a medical model of disability. It is based on a 'biopsychosocial' approach, which views disability from various perspectives, combines medical and social understandings and recognises the relevance of a number of different factors to the experience of disability.

IV. THE DEFINITION OF DISABILITY IN THE CRPD

As explained in the previous Parts, the British 'social model' approach understands disability as a social situation, and particularly a form of social oppression imposed on people with impairments, which is caused by social and environmental barriers that exclude them from participating in society and which is entirely distinguished from their

⁶¹ *ibid.*

⁶² George Engel, 'The Need for a New Medical Model: A Challenge for Biomedicine' (1977) 196 *Science* 129. Note that, as Nassir Ghaemi states, the term actually originated in 1954 and was invented by Roy Grinker, who 'applied it to psychiatry to emphasise the "bio" against psychoanalytic orthodoxy'; Engel then used it in 1977 to privilege the 'psychosocial' over the 'bio': Nassir Ghaemi, 'The Rise and Fall of the Biopsychosocial Model' (2009) 195 *The British Journal of Psychiatry* 3, 3.

⁶³ *ibid.* 130.

⁶⁴ WHO, *ICF* (n 9) 8.

⁶⁵ *ibid.* 17.

⁶⁶ For an overview of critiques of the ICF, see Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' (n 58) 60-63. See also Barnes and Mercer, *Exploring Disability* (n 14) 38-40.

individual impairment. On the other hand, the ICF describes disability as the multi-dimensional and interactive experience of a wide range of difficulties in functioning; in particular, these difficulties include impairments, limitations in performing activities and restrictions in participating in life situations, and arise out of the complex interaction between health conditions, personal factors and barriers in the physical and social environment.

Having identified how disability is understood under the 'social model' approach and in the ICF, this Part will now determine which understanding aligns more closely to the definition of disability in the text of the CRPD.⁶⁷

The definition of disability in the final text of the CRPD

The relevant definition is found in the Preamble to the CRPD, which states that:

[D]isability is an evolving concept and ... 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.⁶⁸

It would also be useful at this point to note that the ICF defines disability as follows:

Disability ... denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).⁶⁹

In considering whether the definition of disability in the CRPD is closer to the British 'social model' or the ICF, two key observations can be made; one supports the argument that the CRPD adopts an understanding of disability similar to the ICF, and the other the argument that the CRPD does not adopt the British 'social model' approach.

The first observation concerns the use of the word 'interaction'. In particular, disability is defined in the CRPD as resulting from the *interaction* between persons with impairments and attitudinal and environmental barriers. This definition resembles the ICF conceptualisation of disability as the interaction between individuals with health conditions and their personal and environmental factors. Disability in both the CRPD and the ICF is understood dynamically, as an interactive process between individuals and their environment; it is also noteworthy that the CRPD uses the exact same word that is used in the ICF, namely 'interaction'. In contrast, the British 'social model' understands disability statically, as the result of social barriers that exclude people with impairments from participating in society. It therefore seems that the CRPD

⁶⁷ Note that the CRPD, beyond the issue of whether or not it adopts the British 'social model', views disability from a human rights perspective, moving away from charity-based approaches. The shift from a 'charity' towards a 'human rights' approach was highlighted in the well-known study of Gerard Quinn and Theresia Degener on the UN protection of the human rights of people with disabilities. The human rights perspective on disability, as stated in the report, views people with disabilities as 'subjects' and not as 'objects'; not as 'problems', but as 'holders of rights': Gerard Quinn and Theresia Degener, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (United Nations 2002) 1.

⁶⁸ CRPD, PmbI, para (e) (emphasis added). Note that there is some uncertainty as to the role and importance of a Preamble in international law: see for example Max Hulme, 'Preambles in Treaty Interpretation' (2016) 164 U Pa L Rev 1281.

⁶⁹ WHO, *ICF* (n 9) 213.

defines disability in a way that aligns more closely to the ICF than the British 'social model' approach.

The second observation concerns the use of the word 'hinders' in the CRPD. In particular, the definition of disability contains a relative clause, which reads: 'that *hinders* their full and effective participation in society on an equal basis with others'. In order to determine whether the CRPD adopts the British 'social model' approach or not, it is important to identify whether that clause relates to the noun 'interaction', or the noun 'barriers'; thus, whether it is the attitudinal and environmental barriers that hinder participation in society, or the interaction between persons with impairments and these barriers. Since the CRPD uses the singular form of the verb 'hinder', there can be no doubt that it relates to the also singular word 'interaction', instead of the plural 'barriers'. Therefore, the view taken in the CRPD is that the participation of persons with impairments in society is hindered by the interaction between these persons and attitudinal and environmental barriers. Importantly, it is not the barriers that hinder participation in society, but rather the interaction between persons and barriers. This is not, however, the approach adopted by the British 'social model'. In particular, the British 'social model' suggests that social participation is only hindered by the presence of disabling barriers; thus, persons with impairments have nothing to do with the social exclusion they face, and no connection or interaction exists between them and the barriers that prevent them from participating in society. Had the CRPD wished to adopt this approach, it would have used the plural form of the verb 'hinder', in order to emphasise that social exclusion is caused only by disabling barriers.⁷⁰

It is also important to note that it would be wrong to assume that the use of the word 'barriers' in the CRPD definition points towards the adoption of the British approach; although this particular term has been associated with the 'social model of disability',⁷¹ it is *also* used in the ICF. In particular, the ICF recognises the relevance of environmental factors to human functioning or disability, and uses the term 'barriers' to denote the negative effects of the environment - as opposed to 'facilitators', which are positive effects of the environment.⁷²

Based on the above considerations, it can be argued that the CRPD does not adopt the British 'social model' approach to disability, but rather defines disability in a way similar to the ICF understanding. This argument has also been made by Jerome Bickenbach, who stated in 2009 that 'the link between the ICF conception of disability and CRPD is obvious upon inspection',⁷³ and again in 2012 that 'the ICF conceptualization does surface in the preamble of the CRPD'.⁷⁴ However, the connection between the CRPD and the ICF has often been overlooked in the CRPD

⁷⁰ To clarify, the sentence in that case would read: 'Disability ... results from the interaction between persons with impairments and attitudinal and environmental barriers that *hinder* their full and effective participation in society on an equal basis with others.' Thus, the verb 'hinder' would relate to the noun 'barriers' and it would be clear that it is the barriers that hinder participation in society, not the interaction between these barriers and persons with impairments.

⁷¹ See for example the DPI definition of disability: DPI (n 26); John Swain and others (eds), *Disabling Barriers – Enabling Environments* (SAGE 1993). See also Finkelstein (n 18) 22.

⁷² WHO, *ICF* (n 9) 22, 171. For the full definition of 'barriers', see WHO, *ICF* (n 9) 214.

⁷³ Jerome Bickenbach, 'Disability, Culture and the UN Convention' (2009) 31 *Disability and Rehabilitation* 1111, 1112.

⁷⁴ Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' (n 58) 60.

literature; in fact, as will be seen below, many authors seem to hold the mistaken view that the CRPD adopts the so-called 'social model of disability'.

It should be noted at this point that there can be some confusion regarding the meaning of the term 'social model of disability'. As mentioned in Part II, the 'social model of disability' is a unique, strong social approach to disability, developed in Britain in the 1970s and 1980s. It denies any causal link between impairment and disability and suggests in particular that disability is entirely caused by social barriers that prevent people with impairments from participating in society. The British 'social model' approach is very well known and most authors are familiar with it. It would therefore be reasonable to assume that they use the term 'social model of disability' correctly, as a reference to the British approach.

However, this term is sometimes used in the wrong way. As already mentioned, the British 'social model' is only one of the various social approaches to disability that have been developed; others include the Nordic 'relational' understanding and the North America 'minority group' approach. These are weaker approaches, and they do not share the special characteristics of the British 'social model'. They simply emphasise the role of society and the environment in creating disability, without entirely rejecting its medical or individual aspects. However, because of the popularity of the British approach, the term 'social model of disability' might be used, incorrectly, as a general reference to approaches that view disability from a social perspective, without intention to specifically refer to the British approach. Thus, some authors might use the term 'social model', when they would actually mean 'social approach'.

As noted above, there seems to be a mistaken view that the CRPD adopts the 'social model of disability'. In the examples mentioned below, the authors use the term 'social model'; it is not clear, however, what they mean by using that term. They could refer to the British approach, or they could simply imply that the CRPD generally adopts a social approach to disability. As previously stated, the former possibility is more probable and it will therefore be assumed that, by using the term 'social model', they refer to the British approach. Nevertheless, it can be argued that in any case this view is wrong. If they refer specifically to the British 'social model', they are mistaken because, as already found, the CRPD does not adopt this approach. If they generally refer to a social approach, they are mistaken too. The statement that the CRPD adopts a social approach to disability, albeit not entirely wrong, is inaccurate; the CRPD, as found above, adopts an approach which seems closer to the ICF 'biopsychosocial' approach to disability. It would therefore be inadequate to simply state that it adopts a social approach, because it actually adopts an approach which is based on a 'synthesis' of the medical and social 'models' of disability.⁷⁵

Before mentioning a few examples of authors who misinterpret the CRPD definition of disability, it is worth noting an author who describes it correctly. Eilionóir Flynn states that the definition of disability adopted in the CRPD is 'based on the understanding that disability is not solely the result of a medical impairment, but also stems from societal barriers to participation'.⁷⁶ Flynn refers to 'societal barriers', but carefully avoids mentioning the 'social model'. Furthermore, by using the word 'solely', she

⁷⁵ WHO, *ICF* (n 9) 10.

⁷⁶ Eilionóir Flynn, *From Rhetoric to Action: Implementing the UN Convention on the Rights of Persons with Disabilities* (CUP 2011) 18.

recognises that the CRPD understanding is that disability is caused by both impairment and barriers. Therefore, despite the lack of reference to the ICF, her statement is entirely accurate and consistent with the language of paragraph (e) of the Preamble.

Usually, however, the definition of disability in the CRPD is misunderstood. Rosemary Kayess and Phillip French state in *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, which is one of the leading texts on the CRPD, that:

[P]aragraph (e) of the Preamble makes it clear that disability is to be understood according to the precepts of the social model. 'Disability' is conceptualised as the product of the interaction of persons with impairments with environmental barriers that hinder their full and effective participation in society on an equal basis with others.⁷⁷

Stefan Trömel also notes that 'the paragraph in the preamble provides a social model definition of disability, based on the interaction between impairment and barriers'.⁷⁸ Charles O' Mahony states that 'there is no doubt that the CRPD has adopted the approach of the social model of disability'.⁷⁹ Shivaun Quinlivan and Peter Bartlett refer to the definition of persons with disabilities, found in Article 1 of the CRPD, which reads:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.⁸⁰

It is worth noting that in this definition, the verb 'hinder' clearly relates to the noun 'impairments'. Therefore, like paragraph (e) of the Preamble to the CRPD, Article 1 too recognises that impairments - in interaction with various barriers - may hinder persons with disabilities' participation in society. This is the view adopted in the ICF rather than the British 'social model'. However, Quinlivan states that 'this definition clearly endorses the social model of disability' and goes on to say that 'the focus of this definition is on the barriers and obstacles that hinder or prevent full, equal and effective participation in society ...'⁸¹ Bartlett similarly states that 'the reference to barriers to participation emphasises the social model of disability adopted by the CRPD'.⁸²

Kayess and French, Quinlivan, O' Mahony, Trömel and Bartlett all strongly suggest that the CRPD adopts the 'social model' of disability. The first two go so far as to argue

⁷⁷ Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 HRL Rev 1, 24.

⁷⁸ Stefan Trömel, 'A Personal Perspective on the Drafting History of the United Nations Convention on the Rights of Persons with Disabilities' in Gerard Quinn and Lisa Waddington (eds), *European Yearbook of Disability Law: Volume 1* (Intersentia 2009) 121.

⁷⁹ Charles O'Mahony, 'Legal Capacity and Detention: Implications of the UN Disability Convention for the Inspection Standards of Human Rights Monitoring Bodies' (2012) 16 The International Journal of Human Rights 883, 885.

⁸⁰ CRPD, Art 1.

⁸¹ Shivaun Quinlivan, 'The United Nations Convention on the Rights of Persons with Disabilities: An Introduction' (2012) 13 ERA Forum 71, 76.

⁸² Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 MLR 752, 758.

that this is *clear*,⁸³ and O' Mahony states that *there is no doubt* about it.⁸⁴ As already explained, however, it is far from clear and highly doubtful that disability in the CRPD is understood in accordance with the British 'social model' approach. It is interesting to note that Kayess and French and Quinlivan incorrectly state that, according to the CRPD understanding of disability, participation in society is hindered by the various barriers; however, as mentioned above, the CRPD understanding is that social participation is hindered by the interaction between persons with impairments and disabling barriers. It can therefore be argued that a close examination of the actual wording of the CRPD shows that it resembles the ICF conceptualisation of disability.

The reason why the ICF has not been explicitly endorsed in the CRPD is possibly because of the significant disagreement and the concerns that were expressed during the CRPD negotiations. In particular, the adoption of the ICF understanding was opposed by those in favour of a more radical approach to disability, such as the British 'social model'. This has been acknowledged by Kayess and French, who note that 'any attempt to use the ICF to interpret the CRPD will inevitably be fraught with controversy',⁸⁵ and also by Bickenbach, both in 2009 and 2012. In particular, Bickenbach mentioned in 2009 that 'the political environment surrounding the drafting of CRPD made the explicit adoption of the ICF conception politically inexpedient',⁸⁶ and in 2012 that the ICF is 'never referenced and only paraphrased'⁸⁷ in the CRPD. It is therefore useful to examine now the discussion that took place during the CRPD negotiations regarding the definition of disability.

The discussion on the definition of disability during the CRPD negotiations

The negotiations of the CRPD were conducted by the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities (Ad Hoc Committee).⁸⁸ The Ad Hoc Committee met in eight sessions; the process of negotiation and drafting began in August 2002 and ended in December 2006.

During its Second Session, held from 16 to 27 June 2003, the Ad Hoc Committee decided to establish a 'Working Group',⁸⁹ with the task to draft a text of a convention on the rights of persons with disabilities. This decision was endorsed by the General Assembly in its Resolution 58/246 of 23 December 2003.⁹⁰ The 'Working Group' met from 5 to 16 January 2004 and, based on that draft text, the Member States and

⁸³ Kayess and French (n 77) 24; Quinlivan (n 81) 76. Note that Kayess and French mention that the 'social model' influenced the development of the CRPD primarily as a 'disability rights manifesto', rather than a 'theory of disability'. As they explain, the former tends to see disability from a 'radical social constructionist view ... in which impairment has no underlying reality': Kayess and French (n 77) 7.

⁸⁴ O'Mahony (n 79) 885.

⁸⁵ Kayess and French (n 77) 24.

⁸⁶ Bickenbach, 'Disability, Culture and the UN Convention' (n 73) 1112.

⁸⁷ Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' (n 58) 60.

⁸⁸ Resolution on a Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities, 19 December 2001, UN Doc. A/RES/56/168, 26 February 2002.

⁸⁹ Report of the Ad Hoc Committee on its Second Session, 3 July 2003, UN Doc. A/58/118 and Corr. 1, para 15.

⁹⁰ Resolution on the Ad Hoc Committee, 23 December 2003, UN Doc. A/RES/58/246, 11 March 2004, para 3.

observers negotiated in the following sessions the final text of the CRPD. Also, following the Sixth Session and pursuant to General Assembly Resolution 60/232 of 23 December 2005,⁹¹ the Chairman of the Ad Hoc Committee (Don MacKay, Ambassador of New Zealand) prepared a draft text that was considered during the Seventh Session, held from 16 January to 3 February 2006.

The fact that the definition of disability was the subject of much debate during the negotiations is well documented.⁹² The 'Working Group' draft text intended to define disability in the Definitions Article (then draft Article 3), alongside the other definitions; the term was nevertheless left undefined. Instead, it was stated in the footnote that:

Many members of the Working Group ... suggested that the term 'disability' should be defined broadly. Some members were of the view that no definition of 'disability' should be included in the Convention, given the complexity of disability and the risk of limiting the ambit of the Convention. Other delegations pointed to existing definitions used in the international context, including the [ICF]. There was general agreement that if a definition was included, it should be one that reflected the social model of disability, rather than the medical model.⁹³

During the Third Session, the Ad Hoc Committee undertook a reading of the 'Working Group' draft text; it was decided however not to consider Article 3, but to defer discussion to the next Session.⁹⁴

The definition of disability in draft Article 3 was considered during the Fourth Session of the Ad Hoc Committee. Importantly, there was significant disagreement not only as regards the proper definition of disability, but also the question of whether disability should be defined at all in the convention. It would be useful to note now the main points that were made. The delegation from the Netherlands (on behalf of the EU) argued against definitions of 'disability' or 'persons with disabilities', on the basis that 'they risk becoming exclusive instead of inclusive'.⁹⁵ The delegation from Canada also noted that 'definitions on disability tend to change ... and it will be difficult to come up with a definition of disability that stands the test of time'.⁹⁶ On the other hand, the delegation from Australia supported defining disability, but suggested that it should be 'broad and inclusive'.⁹⁷ The delegation from the National Human Rights Institutions also warned that 'there is a danger in not defining disability – States may refuse to ratify the convention if its meaning and obligations are uncertain'.⁹⁸ Regarding the approach taken in relation to disability, the delegation from Australia stated that, the importance of the 'social model of disability' notwithstanding, 'disability seen purely as

⁹¹ Resolution on the Ad Hoc Committee, 23 December 2005, UN Doc. A/RES/60/232, 31 January 2006, para 4.

⁹² Arlene Kanter, 'The Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities' (2006-2007) 34 *Syracuse J Int'l L & Com* 287, 291; Anna Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-2007) 34 *Syracuse J Int'l L & Com* 563, 593; Kayess and French (n 77) 23; Gerard Quinn, 'A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities' in Gerard Quinn and Lisa Waddington (eds), *European Yearbook of Disability Law: Volume 1* (Intersentia 2009) 101.

⁹³ Report of the Working Group to the Ad Hoc Committee, 27 January 2004, UN Doc. A/AC.265/2004/WG.1, fn 12.

⁹⁴ Daily Summary of Discussion at the Third Session, 24 May 2004, Original MS Word version, 10 <<http://www.un.org/esa/socdev/enable/rights/ahc3sum24may.htm>> accessed 31 July 2017.

⁹⁵ Daily Summary of Discussion at the Fourth Session, 23 August 2004, Original MS Word version, 9-10 <<http://www.un.org/esa/socdev/enable/rights/ahc4sum23aug.htm>> accessed 31 July 2017.

⁹⁶ *ibid* 11.

⁹⁷ *ibid*.

⁹⁸ *ibid* 13-14.

a function of the environment would render a definition unworkable'.⁹⁹ The delegation from the Republic of Korea also pointed out that 'the definition of disability has evolved and ICF now embraces a broad, social model definition'.¹⁰⁰

Article 3 and the definition of disability were not discussed during the Fifth and Sixth Sessions of the Ad Hoc Committee. The Chairman, in the draft text that he prepared for discussion at the Seventh Session, stated that:

Views are divided as to whether it is necessary to define 'Disability' and 'Persons with disabilities'. I tend to think that we don't, as this will be very difficult, and there is a risk that we will unintentionally exclude someone.¹⁰¹

The Definitions Article (now Article 2) was discussed during the Seventh Session of the Ad Hoc Committee and included a lengthy debate regarding the definition of disability. The Chair, in summarising the relevant views heard, noted that there was still disagreement over the inclusion of such a definition in the convention; this issue could be addressed either by referencing a definition or the scope of the meaning of disability in the Preamble, or by including such a reference in the final report of the Ad Hoc Committee.¹⁰² He recognised however that the 'overall consensus' would be to include a definition of disability in Article 2, and finally stated that 'a proposal addressing the issue would be forthcoming'.¹⁰³ Indeed, a possible definition of disability was later proposed by the Chair:

'Disability' results from the interaction between persons with impairments, conditions or illnesses and the environmental and attitudinal barriers they face. Such impairments, conditions or illnesses may be permanent, temporary, intermittent or imputed, and include those that are physical, sensory, psychosocial, neurological, medical or intellectual.¹⁰⁴

It can be noted that the Chair's proposed understanding of disability, as resulting from the interaction between persons with impairments and the barriers they face, is in line with the ICF conceptualisation. It should also be noted that several delegations referred to the ICF understanding of disability during the discussion on the Definitions Article at the Seventh Session. In particular, the ICF was mentioned by the delegation from Australia as a possible source of a definition for disability.¹⁰⁵ The delegation from Australia also referred to the social model, but opposed the adoption of a 'strict social model approach' that would release States from their obligations towards persons with disabilities once the barriers created by society were removed.¹⁰⁶ The delegation from Serbia and Montenegro mentioned the ICF as well, and suggested a possible reference to the ICF, or the social model approach, in the Preamble.¹⁰⁷ The delegation from Norway supported Australia's proposal for a definition of 'disability' along the lines of the ICF and social model definitions, and stated that they would be 'flexible' about

⁹⁹ *ibid* 11.

¹⁰⁰ *ibid* 10.

¹⁰¹ Letter dated 7 October 2005 from the Chairman to all members of the Committee, 14 October 2005, UN Doc. A/AC.265/2006/1 para 17.

¹⁰² Daily Summary of Discussion at the Seventh Session, 31 January 2006, Original MS Word version, 21 <<http://www.un.org/esa/socdev/enable/rights/ahc7sum31jan.htm>> accessed 31 July 2017.

¹⁰³ *ibid*.

¹⁰⁴ Possible Definition of 'Disability': Discussion Text Suggested by the Chair <<http://www.un.org/esa/socdev/enable/rights/ahc7pddisability.htm>> accessed 31 July 2017.

¹⁰⁵ Daily Summary of Discussion at the Seventh Session (n 102) 8.

¹⁰⁶ *ibid*.

¹⁰⁷ *ibid* 9.

including such a definition in the Preamble, as suggested by Serbia and Montenegro.¹⁰⁸ The delegation from Jamaica was drafting legislation on people with disabilities at the time, and mentioned that they ‘had decided upon the WHO-ICF approach, which distinguishes between impairment, disability and handicap’;¹⁰⁹ it should be noted however that the distinction between impairment, disability and handicap is made, not in the ICF, but in the ICIDH. The delegations from India and Chile also referred to the ICF in discussing the possible definition of disability.¹¹⁰ Finally, the delegation from the International Disability Caucus (IDC)¹¹¹ described the ICF as ‘very controversial’ and noted that many disability organisations do not accept it as a definition of disability.¹¹² This lack of approval seems to be the reason why, as mentioned above, the similarity between the CRPD and the ICF understandings of disability, although readily apparent, is not expressly recognised either in the CRPD literature or the text itself.

During its Eighth and final Session, the draft text of a convention on the rights of persons with disabilities was concluded, and it was adopted by the Ad Hoc Committee on 25 August 2006. The Ad Hoc Committee then decided to establish an open-ended ‘Drafting Group’, with the task to ensure ‘uniformity of terminology throughout the text of the draft convention, harmonising the versions in the official languages of the United Nations’;¹¹³ following that, on 5 December 2006 recommended to the General Assembly for adoption a draft resolution entitled ‘Convention on the Rights of Persons with Disabilities’.¹¹⁴

Although the ‘Drafting Group’ produced four revised texts, the definition of disability in this draft convention was eventually adopted in the final text of the CRPD without a single modification. In particular, disability was defined in the preamble of the draft convention as follows:

[D]isability is an evolving concept and ... 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 others¹¹⁵

It is worth noting that in the first revised text of the ‘Drafting Group’, it was suggested to add a comma after the word ‘barriers’, ‘to ensure that the phrase thereafter refers to “interaction” and not to “barriers”’.¹¹⁶ Apparently, it was considered significant for the ‘Drafting Group’ to leave no doubt about the position in the CRPD regarding the cause of social exclusion and disability. This therefore supports the argument made above, namely that the CRPD takes the view that participation in society is hindered not by

¹⁰⁸ *ibid.*

¹⁰⁹ *ibid.* 14.

¹¹⁰ *ibid.* 15-16.

¹¹¹ The International Disability Caucus (IDC) was a coalition of international, regional, and national disabled people’s organisations (DPOs) and allied non-governmental organisations (NGOs).

¹¹² Daily Summary of Discussion at the Seventh Session (n 102) 17.

¹¹³ Interim Report of the Ad Hoc Committee on its Eighth Session, 1 September 2006, UN Doc. A/AC.265/2006/4, para 13.

¹¹⁴ Final Report of the Ad Hoc Committee, 6 December 2006, UN Doc. A/61/611.

¹¹⁵ Interim Report of the Ad Hoc Committee on its Eight Session (n 113) Annex II.

¹¹⁶ Ad Hoc Committee, Draft Convention on the Rights of Persons with Disabilities and Draft Optional Protocol: First revised text, 13 September 2006, fn 3 <<http://www.un.org/esa/socdev/enable/drafting.htm>> accessed 17 July 2017.

barriers alone, but by the interaction between barriers and persons with impairments, and also that the difference between the two opposing views is actually meaningful.

The comments made in the second revised text - as well as the third and fourth texts - simply regarded the use of correct grammar. It was noted in particular that 'if a comma is put after barriers, in that case "that" must be replaced by "which"; there can be no comma in front of "that".¹¹⁷ The editor also recommended putting a comma after 'interaction', if the comma after 'barriers' was to be kept.¹¹⁸ In the third revised text, 'that' was still replaced by 'which', but the commas were omitted.¹¹⁹ Finally, 'that' replaced 'which' in the fourth revised text of the 'Drafting Group', and therefore it was decided to maintain in the CRPD the old definition of disability.¹²⁰ It seems indeed that the proposed changes were not actually needed; in fact, if adopted, they would have made the meaning of the text less understandable.

The examination of the discussion on the definition of disability during the CRPD negotiations reveals that the Ad Hoc Committee intended to emphasise that disability is the result of the interaction between barriers and persons with impairments, which is the same way that the ICF understands disability. The proposals of the 'Drafting Group', as mentioned above, and especially their will to ensure that participation in society is hindered by both impairment and barriers, confirm that they adopt a different view than the British 'social model', which only regards disabling barriers as the cause of social exclusion. It therefore seems to be confirmed that the CRPD does not adopt the British 'social model' approach to disability, but rather defines disability in a way similar to the ICF understanding.

V. CONCLUSION

This article sought to determine whether the CRPD adopts the 'social model' approach to disability or not. To that end, it first examined the 'social model', which is the most commonly known social approach to disability. This understanding, developed in Britain during the 1970s and 1980s, rejects the view that disability is an individual and medical problem caused by impairment, and rather suggests that disability is a form of social oppression, caused only by social barriers that exclude people with impairments from participation in society.

It then went on to examine a more balanced - in the sense that it integrates medical and social understandings - approach to disability, found in the ICF. Adopting a 'biopsychosocial' approach, the ICF understands disability as multi-dimensional and interactive. Disability is conceptualised in particular as the experience of a wide range of problems in functioning, including impairments, limitations in performing activities

¹¹⁷ Ad Hoc Committee, Draft Convention on the Rights of Persons with Disabilities and Draft Optional Protocol: Second revised text, 3 October 2006, fn 4 <<http://www.un.org/esa/socdev/enable/drafting.htm>> accessed 31 July 2017.

¹¹⁸ *ibid.* To clarify, the sentence read: '... disability results from the interaction, between persons with impairments and attitudinal and environmental barriers, which hinders ...'

¹¹⁹ Ad Hoc Committee, Draft Convention on the Rights of Persons with Disabilities and Draft Optional Protocol: Third revised text, 10 October 2006 <<http://www.un.org/esa/socdev/enable/drafting.htm>> accessed 31 July 2017. The sentence read: '... disability results from the interaction between persons with impairments and attitudinal and environmental barriers which hinders ...'

¹²⁰ Ad Hoc Committee, Draft Convention on the Rights of Persons with Disabilities and Draft Optional Protocol: Fourth revised text, 30 October 2006 <<http://www.un.org/esa/socdev/enable/drafting.htm>> accessed 31 July 2017.

and restrictions in participating in life situations; this experience is seen as arising out of the complex interaction between a health condition, personal factors and barriers in the physical and social environment.

The article finally examined the definition of disability in the text of the CRPD. The CRPD defines disability as resulting from the interaction between persons with impairments and attitudinal and environmental barriers. It also states that this interaction hinders the full and effective participation of persons with impairments in society on an equal basis with others. On the basis of this definition, and particularly the use of the words 'interaction' and 'hinders', it was found that the CRPD does not adopt the British 'social model' approach, but rather defines disability in a way similar to the ICF understanding, although this similarity is often overlooked in the CRPD literature. The final part of the article focused on the discussion during the CRPD negotiations regarding the definition of disability. It was found that the Ad Hoc Committee was aware of the differences between the 'social model' and the ICF approaches to disability, especially in relation to its cause and consequences, and intentionally chose a definition which is closer to the latter.

Demonstrating that the CRPD defines disability, not on the basis of the 'social model', but in a way similar to the ICF understanding may have significant practical implications. The 'social model' has been widely criticised for its limitations, especially for the distinction it makes between impairment and disability and for considering impairment as being entirely irrelevant to the experience of disability. By being connected to the 'social model', the CRPD risks facing the same criticism, being met by governments and policy makers with scepticism or being dismissed. Associating the CRPD with the ICF might therefore facilitate its implementation. At the same time, the valuable insights of the 'social model' would not be lost, as the social dimension of disability and the disabling effect of social and environmental barriers are recognised by the ICF too. The medical dimension is also recognised by the ICF, as well as the relevance of impairment to the experience of disability and the health needs of persons with disabilities. Although highly controversial especially among persons with disabilities, recognising that disability also has a medical aspect should not necessarily be seen as negative and undesirable. Provided that care and treatment is not forced upon them, persons with disabilities might benefit from the connection between the CRPD and the ICF, as understandings of disability that incorporate medical factors have the advantage that, in addition to any relevant social responses, the health needs of persons with disabilities must also be addressed, and appropriate healthcare services must be available to them.

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