The social and human rights models of disability: towards a complementarity thesis

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ABSTRACT

This article aims to reorient thinking about the relationship between the long-standing social model of disability and the rapidly emerging human rights model. In particular, it contests the influential view that the latter develops and improves upon the former (the improvement thesis) and argues instead that the two models are complementary (the complementarity thesis). The article begins with a discursive analysis of relevant documents to investigate how each of the two models has been used in the crafting and monitoring of the UN Convention on the Rights of Persons with Disabilities. This highlights the increasing importance of the human rights model in this policy context. It also provides examples of the operation of the two models which inform the remainder of the discussion. We then critique the comparisons between the models which underpin the improvement thesis; and, drawing on Foucault's technologies of power and Beckett and Campbell's 'oppositional device' methodology, deepen and develop this comparative analysis. The result, we argue, is that the two models have different subjects and different functions. In the human rights context, their roles are complementary and supportive.

1. Introduction

For the past 40 years, 'models' of disability have featured prominently in shaping disability politics, Disability Studies and human rights for disabled people. The 'social model of disability',[1] which presents disability as a form of socially created oppression, has been foundational. This social model, an idea rooted in the disabled people's movement, entails a political repurposing of the idea of 'disability', whereby that term is used to describe the socially created disadvantage and marginalisation experienced by people who have (or are perceived to have) 'impairments'. At its heart is the distinction between socially created exclusion and disadvantage on the one hand, and the particular mind and body traits of individuals on the other. Thus, in 1981, Disabled People's International (DPI) drew a distinction between 'the functional limitation within the individual caused by physical, mental or sensory impairment' and the 'loss or limitation of opportunities to take part in the normal life of the community due to physical and social barriers'[2]; while some years

earlier, the UK-based organisation Union of Physically Impaired Against Segregation (UPIAS) described 'disability' as a form of oppression and as 'something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society'.[3]

From a social model perspective, disability is therefore viewed as a socially produced injustice which it is possible to challenge and eliminate through radical social change. Oliver acknowledged that, when introducing the phrase the 'social model of disability' in the early 1980s, he was drawing upon the distinction originally made between impairment and disability by UPIAS.[4] He helpfully distinguished this social model understanding of disability from an array of traditional approaches which he classified, collectively, as the 'individual model of disability' and which he described as 'locat[ing] the "problem" of disability within the individual and ... see[ing] the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability'.[5]

Since the early 1980s, the social model has generated a wealth of literature which crosses geographical and disciplinary divides. Perhaps unsurprisingly therefore, there are now significant inconsistencies in its articulation and usage.[6] The consequent potential for con- fusion is exacerbated by the fact that the term is often used without an accompanying explanation of exactly how it is understood by the particular author.[7]

Miller is therefore unlikely to be alone in his view that using the social model as an evaluative framework is 'a path fraught with difficulties'.[8] In an attempt to provide some clarity about our own use of the terminology, we will use the term 'social model' here to refer to the approach of UPIAS and DPI set out above and, where necessary, differentiate it from other usage of the phrase by describing it as the UPIAS/DPI version of the social model. An array of alternatives to the social model has emerged over the past three decades. In the context of human rights law and policy, by far the most important and influential of these is the human rights model of disability. According to one of the earliest explanations:

> The human rights model focuses on the inherent dignity of the human being and subsequently, but only if necessary, on the person's medical characteristics. It places the individual centre stage in all decisions affecting him/her and, most importantly, locates the main 'problem' outside the person and in society.[9]

By locating the main problem in societal factors external to the individual, this account highlights similarities between the human rights and social models of disability. Indeed, as Kanter has acknowledged, the two terms are sometimes used synonymously.[10] They are, however, also sometimes presented as contrasting models – with the human rights model being treated as a departure from the social model.[11] Although still relatively new, since the adoption of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2006,[12] use of the human rights model has rapidly increased. Thus, as Section 2 below demonstrates, it is the human rights model, and not the social model, to which the UN Committee on the Rights of Persons with Disabilities (the CRPD Committee) now refers when monitoring the efforts of State parties to implement the CRPD.

It is the relationship between the social and human rights models that provides the focus for this article. The view that the human rights model extends and improves upon the social model is gaining prevalence.[13] We contest this approach, which we term the 'improvement thesis', and argue instead for what we term the 'complementarity

thesis'. According to our complementarity thesis, the relationship between the two models is one in which neither can be viewed as an improvement on the other because each has distinctive roles to play. In the furtherance of human rights for disabled people, these roles are complementary and symbiotic.

The remainder of this article is divided into four sections. Section 2 presents a discursive analysis of the operation of the two models in the making and monitoring of the CRPD. This demonstrates the increasing prevalence of the human rights model in this particular law and policy context; and provides concrete examples of the distinct roles or operations of each of the models. Section 3 sets out the improvement thesis and critiques the comparisons between the models which underpin it. Section 4 develops the complementarity thesis by identifying and explaining the key distinctions between the two models and their roles as what we term 'oppositional devices'. This analysis of their respective functions or operations will be supported by examples drawn from the discussion of the roles played by each model in the making and monitoring of the CRPD in Section 2. Finally, in Section 5, we present our conclusions.

2. Comparing the roles of the two models in the making and monitoring of the UN convention on the rights of persons with disabilities: a case study

2.1. Purpose and method

The drafting of the CRPD, and the CRPD Committee's on-going monitoring of its implementation, provides interesting material for an exploration of the roles played by the social and human rights models. Our study had two main aims: first, to understand the extent to which there has been a shift away from the social model and toward the human rights model in the work of those involved in drafting and monitoring the Convention; second, to identify any particular roles (the operations) performed by the two models in these contexts.

This case study takes the form of a discursive analysis of relevant documentation.[14] For the drafting phase, we analysed records of the discussions of the Ad Hoc Committee (AHC) – the Committee established by the UN General Assembly to draft the CRPD.[15] For the monitoring phase, we analysed concluding observations issued by the CRPD Committee prior to the Summer of 2019. Within each of these documents we carried out electronic searches using the terms 'social', 'human rights', 'model' and 'approach'. The results were then checked for relevance to the social model of disability and the human rights model of disability, with text not connected to discussions of either model being excluded. Adopting an inductive approach, we sought to identify any patterns of usage and explicit or implicit interpretations of each model within the documents.

For these purposes, we adopt a Foucauldian understanding of discourse, as that which shapes and creates meaning-systems which have gained the status of 'truth' and come to determine how we define and organise ourselves and our social worlds.[16] Discourses con- tinually shape and reshape our social interaction. The discourse analysis carried out here provides a basis for reflection, in this Section and in Section 4 below, on how the two models operate; the struggles that have taken place over whether to approach the 'problem' of disability through a social or a human rights model; and how these discourses influence associated institutions and processes.[17]

2.2. Making the convention

2.2.1. Role of the social model

The social model is widely acknowledged to have played a significant role in shaping the CRPD. According to Kayess and French, it exercised an 'enormous influence'[18] over the treaty. Traustadóttir describes it as providing the 'knowledge base which ... informed' the CRPD[19]; and Degener observes that, as the 'motto of the international disability move- ment ... it served as a powerful tool to demand legal reform'.[20] The social model appears to have been understood broadly in this sense during the drafting of the CRPD[21] - although some variation in perspective and understanding of the model was inevitable given the number of people involved in the process and their linguistic, political and geographic diversity.

From our analysis it emerged that reference was made to the social model in four types of context, in each of which it was used to perform a different role: (A) as a general frame of reference; (B) to provide definitions; (C) to promote equality and inclusion; (D) to promote solidarity. These will now be discussed in turn:

(A) use of the social model as a general underpinning frame of reference. A number of references in the AHC documents acknowledge the important role played by ideas connected to the UPIAS/DPI social model of disability. Relatively early in the drafting process, in the AHC's second session in July 2003, attention was drawn to the distinction - so key to the social model of disability - between 'experiences of impairment and experiences of disability'.[22] The significance of this social understanding of 'disability' was stressed by the Costa Rica delegation in the AHC's seventh and penultimate session, when it said:

> The most important point [is] that since this process started there has been a consensus on the fact that the medical model of disability, which looks at disability as a defect or a disease that needs to be cured through medical intervention, has been completely left behind. The model that now prevails is the social model, in which the problem is defined as interaction between the setting in which the person with impairment lives and the person.[23]

That delegation also drew attention to the connection between the social model of disability and human rights, observing that:

> The social model of disability emphasizes that persons with disabilities are prevented from reaching their full potential not because of their impairment, but as a result of legal, attitudinal, architectural, communications and other discriminatory barriers. ... The social model of disability, combined with a rights-based approach: (i) recognizes persons with disabilities as rights-holders who can and should determine the course of their lives to the same extent as any member of society; and (ii) defines limitations imposed by the social and physical environment as infringements on people's rights.[24]

(B) use of the social model to provide definitions. The social model of disability featured in two types of debate concerning definitional issues: first, debates about whether the social model should be explicitly mentioned in the Convention; and second, debates about how disability should be defined, if a definition of it were to be included.

Turning to the first of these issues, early in the life of the AHC (in its third session), India and Jordan proposed that specific mention of the social model should be made in

the 'general principles' article of the Convention[25] - an approach supported by Yemen.[26] In the AHC's eighth and final session, China proposed adding the following paragraph to the preamble:

> Recognizing an evolving concept of disability where disability is a state of participation restriction result[ing] from interaction between an individual with impairments and environmental barriers.[27]

Whilst this proposal did not explicitly mention the phrase 'social model of disability', as the Chair of the AHC acknowledged, it was a proposal that would 'add language reflecting the social model of disability' into the Convention text.[28] With some adjustment, it found expression in the final text of the CRPD, paragraph (e) of the preamble which reads:

> 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.

The second and related issue, of how, if at all, 'disability' should be defined, surfaced at various times in the AHC negotiations.[29] Ultimately, no definition of disability was included. Nevertheless, even at an early stage, there was reportedly 'general agreement' that if a definition was included, it should be one that reflected the social model of disabil- ity.[30] The daily summaries of the AHC's discussions indicate that the relevance of the social model to any definition of, or guidance on, 'disability' appeared to be accepted in statements made by the Republic of Korea,[31] Guatemala,[32] Ethiopia,[33] Israel,[34] Thailand,[35] New Zealand,[36] Norway,[37] Serbia and Montenegro,[38] Disabled People's International[39] the European Disability Forum,[40] the National Human Rights Institutions Group[41] and the International Disability Caucus.[42] Yemen and the Syrian Arab Republic, by contrast, favoured attempts to incorporate elements of both the 'medical' and the 'social' model of disability[43] - an approach which the World Health Organisation asserted had been adopted in its International Classification of Functioning Disability and Health (ICF).[44] Shortly before the AHC's eighth and final session, a declaration was signed by partici- pants (including representatives of governments, disabled people's organisations, national human rights institutions, non-governmental organisations, UN agencies and civil society from the Asia-Pacific region) at a UNESCAP workshop in Bangkok. Amongst the requests included in this document was the call to members of the AHC to ensure that 'any definition of "disability" included in the Convention should reflect a social model approach'.[45] The detailed implications of defining disability in accordance with the social model were, however, not the subject of extensive debate in the published AHC documents - although several references were made to the model by Australia in connec- tion with its arguments for including a definition of disability in the Convention. Thus in the AHC's fourth session Australia noted that, while the 'social model of disability is important, ... disability seen purely as a function of the environment would render a definition unworkable', and took the view that a definition of 'disability' should clearly identify 'the people entitled to protections under the Convention' and that these should include people with 'physical, mental, intellectual disabilities as well as future, past and imputed disabilities'.[46] In the seventh session, Australia proposed a detailed definition of disability based on an articulation of various kinds of impairment or functional limit- ation.[47] According to the daily summary of discussions, Australia stated that 'the social

model of disability offers a theoretical framework by which disability can be understood',a strict view of which may lead to the view that, 'once the barriers created by society are removed, the state has no further obligation toward the person with a disability'.[48] It claimed that the definition it proposed, which drew on the concepts of 'impairment' as well as 'disability', was consistent with the social model.[49] While this approach appears to reflect the basic tenets of the UPIAS/DPI model, the daily summary also reports that Australia described the social model as incorporating '*impairment*, which is the physiological function, *disability*, which recognises the interaction of disability with the environment, and the notion of *handicap*, which refers to the disadvantage created by the impairment or disability'.[50] It should be stressed, however, that the UPIAS/DPI social model does not make any distinction between 'disability' and 'handicap' - using the notion of 'disability' to refer to the disadvantage and oppression caused by environmental, legal, attitudinal and other factors external to individuals with impairments.

As mentioned above, the CRPD includes no formal definition of disability - a term not defined in the Convention's definitions provision (Article 2). Guidance on its meaning is, however, provided in paragraph (e) of the preamble (set out above). This reflects a classic UPIAS/DPI social model understanding of 'disability' which is distinguished from the notion of 'impairment'.

In addition, non-exhaustive guidance about the meaning of the phrase 'persons with disabilities' - the people in whose favour the CRPD should operate - is set out in Article 1, which articulates the purpose of the treaty. According to this:

> 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.[51]

While Article 1's focus on impairment and participation restrictions and inequality resulting from 'various barriers' is closely aligned with the UPIAS/DPI social model, the language of 'persons with disabilities' is not. On the basis of this model of disability, the term 'disabled people' refers to people experiencing a particular type of oppression or disadvantage; and 'people with impairments' refers to people who have some kind of (perceived) functional limitation or body/mind difference. 'Persons with disabilities', however, makes little sense.

Reasons for preferring the terminology of 'people with disabilities' to 'disabled people' are advanced by proponents of 'people first' language,[52] according to which reference to the person should be situated before reference to their (perceived) functional limitations. While the term 'people with impairments' would appear to achieve consistency with the terminological implications of both people first and social model approaches, there is some discomfort with the term 'impairment' - which is sometimes regarded as affirming and reifying the societal norms which stigmatise body-mind difference.[53] In other words, there is an argument that what societies determine to be 'impairments' is socially/culturally determined and a result of 'ableism'.[54] Despite the existence of lively debate about the choice and implications of disability-related terminology, the issue does not surface in the published documents of the AHC and the use of 'people with disabilities' does not therefore appear to have been based on any articulated rationale. The absence of discussion on this terminological point seems likely to be due, at least in part, to the multi-national and multi-lingual nature of the interactions. Some of the

associated complexity is evident from observations such as those of Traustadóttir[55] that the terms 'impairment' and 'disability' do not translate well into any Nordic language.

Whilst explicable, the result is confusing. The CRPD sometimes uses the term 'disability' in the UPIAS/DPI social model sense of societally-created oppression or disadvantage and sometimes uses it to mean 'impairment'. For this reason, Kayess and French argue that:

> In spite of its professed adherence to a social model of disability, ... the CRPD perpetuates, and perhaps now irrevocably entrenches, the contemporary conceptual confusion between impairment and disability.[56]

(C) use of the social model to promote equality and inclusion. The social model was used to bolster arguments against using disability, impairment or diagnosis as justifications for exclusion, segregation, or lower levels of rights protection in AHC debates on four types of issue in particular: first, involuntary detention; second, legal capacity; third, education; and fourth, rehabilitation. The use made of the social model in each of these four types of debate will now be addressed in turn.

First, in relation to involuntary detention, the World Network of Users and Survivors of Psychiatry argued that depriving disabled people of their liberty in circumstances which would not ground deprivations of liberty for non-disabled people would be to impose 'a social disadvantage' on disabled people and 'under the social model, that is discrimination'.[57] In its view, the phrase 'deprivation of liberty shall in no case be based on disability' was preferable to the phrase 'deprivation of liberty shall in no case be based on the existence of disability'. Its explanation for this was that the former 'is simple and clear, and treats disability as a social category comparable to gender and race, which is the position that people with disabilities have asserted throughout the convention process' while [t]he phrase "existence of disability" has a medical model tone'.[58]

Second, in relation to legal capacity, legal rights have very commonly been restricted or removed on the basis of impairment or diagnosis. In the AHC, Thailand noted this as a concern, and acknowledged its inconsistency with the social model. According to the report, it 'expressed support for the social model of disability, i.e. the idea that society imposes disability upon people' and stated that '[l]imiting the legal capacity of people with disabilities would reinforce the medical model of disability'.[59]

Third, in relation to the right to education, reference was made to the social model of disability in connection to arguments for an education system in which disabled people have choices equivalent to those of others. According to the British Council of Organisations of Disabled People in a submission to the AHC:

> Much of the special education system was developed without consultation with persons with disabilities, and it thus reflects the medical model approach, which should now shift to a social model approach.[60]

Similarly, the Centre for Studies in Inclusive Education (UK) urged that the CRPD:

> should fully reflect the social model of disability, focusing government obligations on removing the barriers to full participation in education by persons with disabilities. Education of some learners in separate settings because of their disabilities or impairments reflects and perpetuates a view of disability premised on the medical and charity models of disability.[61]

Finally, the need to articulate the right to rehabilitation in a manner consistent with the social rather than the medical model of disability was stressed by a number of AHC members.[62] This reflects an underpinning concern about traditional tendencies to medicalise all aspects of disabled people's lives at the expense of developing non-medical supports and services essential for independent living and inclusion in education, work and community life. According to the International Disability Caucus:

> An overriding goal of the IDC is that rehabilitation is no longer seen only in the context of health or in the medical model. Habilitation and rehabilitation bring new skills and knowledge that allow the individuals to cope with disability in their daily lives. … Rehabilitation has more to do with education than health.[63]

Rehabilitation International and the International Disability Caucus were of the view that habilitation and rehabilitation should be dealt with in a separate provision from the right to health because 'the placement of both in proximity to health risks reinforcing the medical model of disability and is a violation of the rights and dignity of people with disabilities'.[64] The Israel delegation also supported separating these issues into two separate articles, suggesting (without further explanation) that this would be 'an affirmation of the social model combined with the medical model'.[65] The Costa Rica delegation challenged what it regarded as the mistaken view that dealing with rehabilitation and health in the same provision 'would imply an endorsement of a medical model approach towards reha- bilitation'– arguing that rehabilitation was a key component of a broadly understood right to health but that rehabilitation services need not and should not be framed by a 'medical perspective'.[66]

The use of the social model to support arguments that rights should not be restricted simply on the basis of the existence of an impairment or of a diagnosis is rooted in the political demand, at the heart of the UPIAS/DPI social model, to shift policy responses to disability away from ones in which control over the lives of disabled people is handed over to medical and associated professionals in contexts such as education, employment, family life and healthcare. This concern runs through the entirety of the final text of the CRPD. Its stated purpose is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.[67] It is expressed particularly emphatically in a number of provisions. Most notably, Article 14(1)(b), which states that 'the existence of a disability shall in no case justify a deprivation of liberty'; and Article 23(4), which states that '[i]n no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents'. Furthermore, the requirement that rights should be granted to disabled people 'on an equal basis' with others is all-pervasive in the Convention text.

(D) use of the social model to promote solidarity between people with different impairments. The final context in which reference was made to the social model of disability was in connection with arguments that the text of the emerging Convention should not distinguish between people on the basis of the type or severity of their impairment.[68] The social model responds directly to this concern through its role in uniting people with different types of 'impairment' in efforts to identify and resist disabling societal struc- tures and practices.

This use of the social model of disability to challenge impairment-based legal difference is evident in the following report of a contribution by the International Disability Caucus to the debate at the AHC's seventh session:

> ... many states approach psychosocial disabilities using the medical model approach to 'mental illness'. This excludes people with psychosocial disabilities from the broader realm of people with disabilities and the protections they enjoy. However, the social model approach recognizes that the stigma, prejudices and stereotypes associated with people with psychosocial disabilities are themselves very disabling and often lead to violation of their human rights.[69]

In connection with what eventually became Article 31 on data and statistics, the Lebanon delegation argued that, in order to move from a medical to a social model of disability: 'States should move away from statistical investigations that merely enumerate impairments'.[70]

According to the daily reports of the third and fourth sessions, objections were made to including the term 'severe or multiple' impairments or disabilities by the Canada delegation because such terminology 'creates a hierarchy within the disability community and echoes a medical model rather than a social model of disability'.[71] The World Network of Users and Survivors of Psychiatry and Disabled People's International similarly supported the deletion of this phrase from the draft text, describing it as 'a medical model concept'[72] and as involving 'terms which are based on the medical model in making distinctions among people with disabilities on the basis of severity'.[73]

This same social-model-inspired resistance to distinguishing between people with different types of impairment appears to have been one of the arguments used to oppose proposals to introduce the phrase 'various forms' of impairment or 'disability' into the Convention's text. Thus, in explaining why it could not support a proposal to introduce this phrase into what eventually became Article 8 of the CRPD,[74] the Thailand delegation stated that it 'subscribes to the principle of the social model of disability'[75]; and the Mexico delegation observed that references to 'various forms' of disability 'reflects a medical model perspective'.[76]

The final text of the CRPD makes no reference to the severity of impairment although it does stress 'the need to promote and protect the human rights of all persons with disabil- ities, including those who require more intensive support'[77] – the nature and intensity of support required depending on a whole range of factors. Neither does the CRPD generally refer to type of impairment – although there are two exceptions, both of which are based on reasons which do not undermine the solidarity between people with different impair- ment types.

The first exception – in which reference is made to different types of impairment – is Article 1 of the CRPD. As explained above, this provides guidance on the meaning of 'persons with disabilities', setting out a non-exhaustive list of types of impairment in order to give a sense of the range of impairments. Such an approach was, arguably, helpful in light of concerns that States might otherwise develop restrictive approaches to the width of the population for whom the CRPD is relevant.

The second exception is Article 24(3)(c), according to which States undertake to ensure 'that the education of persons, and in particular children, who are blind, deaf or deafblind,

is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximise academic and social development'. While this is a reference to particular types of impairment, it is not one which differentiates or separates children with such impairments from other disabled people. Instead, it simply draws attention to the need to take the situation of children with the specified impairments into account in the design of education systems and, in so doing, responds to specific concerns raised in the AHC by the representative organisations of people with these types of impairment.[78]

2.2.2. The role of the human rights model

Our searches of the online records of the AHC revealed no mention of the term 'human rights model'. This contrasts sharply with the frequent references made in the AHC discussions to the social model.

There is no explicit mention of the human rights model of disability in the text of the CRPD. Close connections are drawn by human rights model proponents, however, between the content of the CRPD and the human rights model. Authors such as Stein and Stein have argued that the CRPD is 'similarly orientated'[79] to this model and Degener has gone further, describing the CRPD as a codification of the human rights model of disability.[80]

2.3. Monitoring the Convention

2.3.1. Role of the social model

In stark contrast with the AHC debates, the social model has seldom been mentioned in the CRPD Committee's concluding observations. It is explicitly mentioned in only one set of concluding observations – on Peru – where the Committee expressed concern about the lack of 'a coherent and comprehensive strategy to implement the social model that the Convention establishes'[81]; and recommended that steps be taken to

> systematize the collection, analysis and dissemination of data, disaggregated by sex, age and disability; ... and develop gender-sensitive indicators to support legislative developments, policymaking and institutional strengthening for monitoring and reporting on progress made with regard to the implementation of the various provisions of the Convention, taking into consideration the changes from the medical to the social model.[82]

Given the emphasis on the social model of disability in the AHC debates, it is surprising that it has not been mentioned more often in concluding observations. It is noteworthy that the Committee issued its concluding observations on Peru in April 2012, which was very early in its working life – Peru being only the third country to be reviewed.

2.3.2. Role of the human rights model

From its eighth session (in Autumn 2012) onward, the CRPD Committee has made frequent reference to the 'human rights model of disability' and other phrases which seem to be used interchangeably – such as 'human rights-based model of disability',[83] 'human rights model'[84] and, in one instance, 'social and human rights model of disability'[85] and 'human rights model for disability'.[86] We identify four key ways in which use is made of the 'human rights model of disability' in the concluding observations – each of

which will be addressed in the remainder of this section. Prior to considering these, however, it is important to note that the vast majority of references to the model (or a variant of it) are not accompanied by explanation of what the Committee means by it. Reference to the human rights model seems often simply to signal a contrast with, and need for departure from, what the Committee describes as a 'medical model' approach to disability policy (whereby healthcare professionals are granted undue power over the life choices and opportunities of disabled people[87]); and as a form of shorthand for the CRPD and its articulation of the responsibilities of governments to foster and bring about the social change necessary for the protection and promotion of human rights for disabled people. Where concluding observations do provide further explanation of the human rights model, however, details will be highlighted below.

(A) recommendations to embed the human rights model of disability in disability strategies, policy and legislation. First, the human rights model is mentioned in connection with the need for States to embed it into disability strategies and across legislation and policy. An example appears in the Committee's observations on Argentina, where it urged the development of 'a broad and comprehensive strategy to realise all the rights set out in the Convention, taking due account of the human rights model of disability'.[88] Similar observations, focusing on the development of a broad disability or human rights strategy based on the human rights model of disability also appear elsewhere.[89] Frequent reference has also been made to the need for legislation and policy to be reviewed and revised to ensure consistency with the human rights model. Examples include concluding observations in which the Committee has stressed the importance of ensuring consistency with this model in legislation and policy at a general level,[90] and in connection with more specific statutes, policies or initiatives.[91]

The Committee has stressed the need to ensure consistency with the human rights model in connection with the definition of disability used in various laws or policies.[92] The model was also mentioned in connection with disability assessment systems.[93] The following guidance in the Concluding Observations on Poland, which appears in virtually identical language in the concluding observations on Malta, is unusual in providing a detailed elaboration of what the human rights model entails in this context:

> Ensure a disability assessment that fully incorporates a human-rights model of disability and takes a human rights-based approach by, inter alia,
>
> (i) Involving organisations of persons with disabilities in the design of disability assessment mechanisms;
> (ii) Engaging persons with disabilities in generating the information on which disability assessments are made;
> (iii) Eliminating multiple methods of assessment;
> (iv) Making information on assessment requirements accessible and user-friendly'.[94]

(B) recommendations for awareness-raising and training in the human rights model of disability. Second, many of the CRPD Committee's concluding observations mentioned the human rights model of disability in connection with awareness-raising and training. In its concluding observations on Brazil, for instance, the Committee noted that it was 'concerned at the lack of strategies specifically to promote the contents of the

Convention and the human rights model of disability to the general public, public officials and private actors'.[95] As is made clear in various concluding observations, such as those on China, this entails portraying disabled people as 'independent and autonomous rights holders' in awareness-raising programmes.[96] It also entails ensuring that such awareness-raising efforts do not exclude particular groups of disabled people, as illustrated by the Committee's recommendation to Canada that it adopt 'a human rights model of disability that recognizes autistic persons and reinforce[s] their human dignity and value in all public campaigns and programmes to support their inclusion in society'.[97]

Alongside its use in connection with awareness-raising amongst the population at large, the human rights model has sometimes been mentioned in connection with more targeted types of training - particularly for judges and the legal profession and for healthcare professionals. References to the importance of relevant training for healthcare professionals have appeared in numerous concluding observations.[98] In relation to the legal profession, the Committee recommends that steps be taken by the Canadian government to:

> Raise awareness among and develop capacity-building programmes for the judiciary and law enforcement officials about the Convention as a legally enforceable human rights instrument, the human rights model of disability and its principles, and the jurisprudence of the Com- mittee ...[99]

In its concluding observations on Argentina, the Committee similarly recommends training and capacity-building for judges but tailors this recommendation to the specific context of legal capacity. It thus urges the State party to provide 'training workshops on the human rights model of disability' to encourage judges 'to adopt the supported decision-making system instead of granting guardianships or trusteeships'.[100]

(C) concerns about deprivation of liberty and institutionalisation and their inconsistency with the human rights model of disability. Third, reference to the human rights model is often made in connection with concerns about systems that deprive disabled people of liberty and subject them to institutional living. The Committee thus urges Azerbaijan[101] and the Republic of Korea[102] to develop support services in the community and accelerate deinstitutionalisation strategies 'based on the human rights model of disability'. Similar recommendations appear in its concluding observations on Austria[103] and Argentina,[104] but in the specific context of mental health services and practices.

(D) involvement and consultation of representative organisations of disabled people. Fourth, the Committee sometimes links the human rights model to recommendations to ensure that policies or systems are designed and implemented in consultation with, or with the involvement of representative organisations of disabled people. Most commonly, this linkage is made in the context of systems for assessing disability.[105] It is also to be found in other contexts, however, such as the development of disability strategies[106]; international co-operation and sustainable development policies and programmes[107]; and awareness-raising initiatives.[108] This suggests that involvement and consultation, in line with Article 4(3) of the CRPD, is regarded by the Committee as a particular priority of the human rights model.

3. The improvement thesis and its underpinning comparisons

The improvement thesis is most clearly articulated in Degener's account of the human rights model, which she presents in the form of six propositions about how that model differs from the social model.[109] She suggests that there has been a historic progression from a medical model approach, to a social model approach and then to a human rights model approach. Degener links the emergence of the human rights model to the adoption of the CRPD[110] but notes that the term 'human rights model' was used prior to this.[111] She makes frequent reference to the provisions of the CRPD to evidence her account of the human rights model and, as noted above, claims that the CRPD 'codifies the human rights model of disability'.[112]

Stein and Stein's account of the disability human rights paradigm is not dissimilar. They note that, like the social model of disability, it 'stresses society's role in constructing disability, and its responsibility to rectify disability-based exclusion'.[113] At its core is 'individual flourishing' and 'dignity'.[114] According to this paradigm, they suggest, 'disabled persons are entitled to equality by virtue of their equal humanity, not because they satisfy sameness norms'[115] – and 'antidiscrimination as well as equality measures' demanding the investment of resources are recognised.[116] It emphasises the 'indivisibility' and the 'process and outcome of human rights'.[117] While not drawing on the provisions of the CRPD in any detail or describing the CRPD as a codification of the disability human rights paradigm, they state that the CRPD is 'similarly oriented' and that it will 'obligate States to take this approach'.[118]

While Degener states that the historical progression toward the human rights model does not entail the social model being totally replaced, [119] she argues that the human rights model 'builds on',[120] 'develops'[121] and 'moves beyond'[122] the social model and describes as her 'main finding' the observation that 'the human rights model of disability improves the social model of disability'.[123] It is this view of the relationship between the two models that we refer to as the 'improvement thesis'.

As already mentioned, the comparisons or contrasts between the two models underpinning the improvement thesis are set out by Degener in the form of six propositions. The first and sixth of these identify important differences between the two models. The contrast underpinning Proposition 1 concerns the nature of the solidarity claims being made by both models – the focus of the social model being claims relevant to people who have, or who are perceived to have, a particular 'health or body status'[124] or, in the terminology of the UPIAS/DPI model, an impairment; whereas the human rights model concerns claims relevant to all human beings, regardless of their particular health or body status. The contrast underpinning Proposition 6 concerns the type of work done by each of the models. While the social model operates to describe disability, the human rights model codifies the CRPD and as such operates as a much more detailed 'roadmap' for policy development.[125] We do not dispute these distinctions but, as explained in Section 4 below, interpret their implications differently.

The contrasts underpinning the remaining propositions, however, are unconvincing when the social model is understood in the UPIAS/DPI sense. When analysed from this standpoint, the distinctions between the two models on which the remaining propositions rest appear insignificant or illusory.

Proposition 2 rests on Degener's claim that 'the social model approach to disability policy supports anti-discrimination policy and civil rights reforms', whereas the human rights model is 'more comprehensive in that it encompasses both sets of human rights, civil and political, as well as economic, social, and cultural'.[126] Other commentators have also argued that the social model grounds a much narrower class of rights claim than a human rights approach. For example, when arguing for a new disability human rights paradigm in the US, Stein and Stein claim that 'the social model has been proscribed to a rigid concept of formal justice that narrowly treats similarly situated people as alike'[127] and that 'Because social model advocacy is grounded exclusively in formal equality notions, legislatures have promulgated civil rights protection; by definition these antidiscrimination prohibitions do not encompass positive rights'[128]

There is nothing in the UPIAS/DPI version of the social model, however, which prescribes or limits the type of legal or policy measure through which societal processes of disablement should take place. As Oliver observes, 'there are no blueprints to guide its implementation' - it is a 'practical tool' that can be 'adapted to specific local contexts, needs and circumstances'.[129] Its openness to different forms of policy solution also renders the UPIAS/DPI social model potentially useful in cultures where reliance cannot easily or safely be placed on human rights language and frameworks. A sense of the scale of social change envisaged by early proponents of the UPIAS/DPI social model is conveyed by the following words of Finkelstein:

> [The] social model of disability has to do with the creation of a society which enables us to be 'human'- not just access our 'rights' within an existing competitive market society.[130]

Degener's third proposition is that 'the social model of disability neglects the fact that disabled persons might have to deal with pain, deterioration of quality of life, and early death due to impairment' whereas 'the human rights model of disability acknowledges these life circumstances and demands them to be considered when social justice theories are developed'.[131] Unlike the social model, it is claimed, the human rights model 'values impairment as part of human diversity'.[132] Degener is not alone in raising concerns about the neglect of impairment by the social model. Shakespeare and Watson have drawn attention to such concerns in connection with an understanding of the social model they term the 'strong' version,[133] in which the issue of impairment is not acknowledged or discussed. They express concern that 'many British activists in their public discourse use exactly this "strong" version of the social model'.[134] Such stifling of the acknowledgement of impairment and what Thomas terms 'impairment effects',[135] as Degener points out, has been the subject of powerful and persuasive feminist critique.[136]

It should be pointed out, however, that the UPIAS/DPI version of the social model only makes sense if there is some recognition - within the model - of the notion of impairment. While the purpose of the model is to focus attention on social change, such change will be ineffective unless it is responsive to and inclusive of different impairment types, effects and needs. Understood in this way, Degener's observation that the human rights model acknowledges impairment-effects 'and demands them to be considered when social justice theories are developed'[137] applies equally to the social model.

Another key claim made about the human rights model in the third proposition applies equally to the UPIAS/DPI social model. This is that the model 'values impairment as part of human diversity'.[138] As is recognised in the first proposition, the notion of impairment

is central to the social model. Its purpose is to achieve social change, driven by the importance of adequately valuing people with impairments. In light of these reflections, any differences between the social and human rights model contained in the third proposition seem to be relatively minor.

The fourth proposition is that 'the social model of disability neglects identity politics as a valuable component of disability policy, whereas the human rights model offers room for minority and cultural identification'.[139] The focus here is on the importance of recognising and valuing the political identity of different groups of disabled people – people who are drawn together, for example, because of a shared experience of a particular impairment or because of a combination of impairment and other characteristics (such as gender, sexual orientation, age, ethnicity or religion). Degener observes that, unlike the social model, the human rights model has space for 'minority and cultural identification',[140] 'gives consider- ation to different layers of identity' and 'acknowledges that disabled persons may be male or female, non-whites, children, or migrants'.[141]

Concerns have certainly been expressed over the years about the lack of diversity within disabled people's movements and their failure to embrace adequately issues of intersectional disadvantage and multiple identity. We suggest, however, that these failings do not stem from the UPIAS/DPI social model itself. Giving attention to effecting social change, in line with this social model, requires an in-depth understanding of the way in which disablement is experienced differently by different people – because of factors including impair- ment-type, gender, sexuality, ethnicity, socio-economic status, age and religion.[142]

The fifth proposition concerns policies designed to prevent impairment. According to Degener, 'while the social model of disability is critical of prevention policy' the human rights model offers a means for assessing the extent to which impairment-prevention pol- icies are required in order to protect the human rights of disabled people.[143] The CRPD (which, as already noted, is treated as a codification of the human rights model) makes it clear that, as part of implementing disabled people's right to health, States parties must take steps to ensure equal access to public health programmes and other health ser- vices and provide 'services designed to minimize and prevent further disabilities'.[144] Prevention of impairment for the population more generally, however, is not required by the CRPD – with the result that investment in such programmes cannot be included by States in sums they claim to be spending on disabled people or disability rights.

As Degener stresses, the focus of the social model's criticism of impairment-prevention programmes is not public health policies targeted at reducing the risk of injury, illness or impairment per se, but the negative and tragedy-ridden images associated with impair- ment which are often included in such initiatives. Such images and language have the effect of creating and entrenching disabling attitudes and, as such, would indeed run counter to the UPIAS/DPI social model. They would similarly run counter to the human rights model and, more particularly, Article 8 of the CRPD which focuses on awareness-raising and the combatting of disability stereotypes and prejudices. In this respect therefore, the two models are in alignment.

The models are also, we suggest, aligned in requiring healthcare systems to be inclusive of people with impairments and to provide services which minimise the risk of avoidable deterioration. As Oliver stresses, the social model 'does not ignore questions and concerns relating to impairment and/or the importance of medical and therapeutic treatments' but 'acknowledges that in many cases, the suffering associated with disabled lifestyles is due

primarily to the lack of medical and other services'.[145] Interestingly, Oliver also dismissed the idea that there was a 'medical model of disability', arguing that 'there is instead, an individual model of disability of which medicalisation is one significant component'.[146] The existence of any substantive difference between the two models on the issue of impair- ment-prevention policies is therefore questionable.

4. The complementarity thesis and its underpinning comparisons

4.1. Different types of model

4.1.1. The proliferation of models

The term 'model' is used in a multitude of contexts and for as many purposes. Frigg and Hartmann list the following as examples of identified model types: 'Probing models, phe- nomenological models, computational models, developmental models, explanatory models, impoverished models, testing models, idealised models, theoretical models, scale models, heuristic models, caricature models, didactic models, fantasy models, toy models, imaginary models, mathematical models, substitute models, iconic models, formal models, analogue models and instrumental models'.[147] In the specific context of disability, references can now be found to the social, minority, Nordic, affirmative, cul- tural, biopsychosocial and human rights models of disability, to name but a few.

It is not difficult to understand why models have proliferated. The early and continuing influence of the social model of disability is no doubt an important factor because it estab- lished the notion of a 'model' as fundamental to disability politics and scholarship. Later models have generally been developed to signify some kind of departure from or refine- ment of the social model or introduced in the hope that they will build on or re-invigorate the momentum toward activism and social change previously achieved by the social model. This is illustrated by the calls for a new model made by some of the UK disability activists who participated in a recent research project led by Maria Berghs.[148] In their view, a new model – a 'social model of human rights'- might be needed to help challenge the negative disability-related impact on equality, social protection and other human rights of policies such as austerity and the shrinking of welfare states.

Nevertheless, there is a danger that multiplying models simply multiplies confusion. It is easy to sympathise with Mike Oliver's sentiment that:

> As the person who invented the term the 'social model of disability', though not the ideas behind it, I find the arrival of all these different models confusing rather than helpful.[149]

If such confusion is to be avoided, clarity about what is being modelled is essential.

4.1.2. The social model – a descriptive and heuristic model of disability

The subject or focus of the UPIAS/DPI social model is 'disability'. It provides an ontology of disability in that it describes the process of disablement and defines disability as a form of social oppression.

The distinction between the descriptive role of a model and the explanatory role of a theory emerges from venerable work such as that of Hawes in 1975.[150] As a descriptive model, the UPIAS/DPI social model of disability has been distinguished from explanatory theories of disablement.[151] Thomas, for instance, notes that the role of the social model is

not to explain how or why disabling barriers exist and persist – such explanations instead being shaped by 'one's theoretical perspective'.[152]

The UPIAS/DPI model is heuristic in that it provides a simple mechanism by which to identify factors that disable people with impairments – factors which are external to the individual and which are therefore capable of becoming the focus of campaigns for social change. Critiquing the UPIAS/DPI model as though it is an explanatory theory of disablement risks overlooking and even undermining the descriptive and heuristic functions of the model. This is a point powerfully made by a number of disability activists from outside the academy. Richard Light, for instance, has written that:

> It is becoming increasingly clear that one of the key issues in disability activism – the Social Model of Disability – is subject to repeated attacks, particularly within the academic community. What is equally clear is that much of the 'bad press' has been prompted by interpretations of the social model that many of us would find particularly strange. ... We believe that it is time for disabled activists to remind academics that the social model originated with us, and that we still have use for it![153]

The social model thus operates to identify where policy reform is needed. It provides orientation for reform and, as illustrated by its role in the drafting of the CRPD discussed above, fundamental principles to guide social change. Importantly though, it is a model of disability – whereas the human rights model is a model of disability policy. The social model cannot be used to provide a detailed blueprint or roadmap for policy responses to disability – a point made clearly in Degener's first and final propositions and by commentators such as Samaha.[154] The fact that it does not provide a detailed policy blueprint allows space for flexibility with the result that, as Oliver notes, it 'can be adapted to specific local contexts, needs and circumstances'.[155] Its function is not to provide a detailed roadmap for law and policy but rather to provide a tool by which to question and reorient them along with other social structures and systems. It is its redefinition of 'disability' as a form of social oppression and its heuristic qualities that make the social model an effective 'oppositional device' – as will be explained below.

4.1.3. The human rights model – a prescriptive model of disability policy

The focus or subject of the human rights model of disability, by contrast, is not the concept or idea of disability. The model does not provide an obvious ontology of disability. It does not, for instance, understand disability to mean the denial of human rights – an understanding which would entail disability ceasing to be an impairment-based social category and instead becoming a meta-category, applicable to everybody experiencing a denial of human rights regardless of whether or not they have an impairment. An argument to this effect (albeit in a different context) is advanced by Wolbring,[156] who suggests that ableism might be used to describe the oppression experienced by all groups who are marginalised on the basis of their perceived distance from some desired social norm (e.g. a white, Western, heterosexual, working-age, cognitively and physically able, middle-class male). To date, however, no such argument has been made in connection with the human rights model. Accordingly, the focus of the human rights model is not the concept of disability. Rather it provides guidance (and requirements) on policy responses to disability. Consequently, it can be viewed not as a model of disability but as a model of disability policy.

The nature of the human rights model is prescriptive, rather than descriptive, in that it answers the question 'what should we do?' to advance social justice for disabled people. Its answer is that we need to progress disability policy and law reform in line with human rights principles and obligations, as set out in the CRPD.

4.2. Different types of role or operation

4.2.1. The models as oppositional devices

Both the human rights model of disability policy and the social model of disability can be viewed as 'oppositional devices'[157] which operate to enhance social justice for disabled people. Oppositional devices disrupt dominant norms and provoke dissent.[158] They make possible the 'generation, reorganisation and proliferation of ... resistance-practices'[159] and the refashioning of individual and collective bodies. In the remainder of this section, we will examine the distinct operations or functions of the two models by using the oppositional device as an analytical framework in the way developed by Beckett and Campbell.[160] This framework draws on, develops and adapts Foucault's theorisation of power and resistance[161] and his four-fold categorisation of technologies.[162]

Using this framework, we will explore the distinct roles or functions of the two models by reflecting on how they operate as technologies of the first, second and fourth types identified by Foucault – respectively, technologies of production, which operate to produce or transform; technologies of sign system, which allow for the use of signs, statements, symbols and meanings; and technologies of the self, which make it possible for individuals to transform themselves. We will also consider the relationship between the two models and Foucault's third technology type – technologies of what Foucault termed 'power', but which (like Beckett and Campbell) we refer to as technologies of 'discipline', in recognition of the fact that all four technology types may be described as technologies of power. Technologies of discipline, which submit subjects to control and domination, are closely associated with machineries of government which are contested and challenged by oppositional devices. Oppositional devices, however, may themselves sometimes constitute concrete operations of technologies of discipline, as will be demonstrated below in connection with the human rights model.

Using this analytical framework, we present the two models as different types of oppo- sitional device; each harnesses the different technology types differently, in different com- binations and to different ends. While they are distinct, we will show that the two models are in important respects complementary in operation and utility.

4.2.2. The social model

Beckett and Campbell developed their oppositional device framework in the context of the social model of disability. Their analysis has considerable relevance to the current discussion. We draw upon their analysis and expand on it by making connections with the use of the social model in the drafting of the CRPD, explained in Section 2 above.

First, as previously explained, the social model produces the two separate but related concepts of impairment and disability. This is the model operating as a technology of production. Through its identification of disability as socially created, it also produces the concept of an unjust, disabling society with disabling barriers. Further, it produces two categories of person – the disabled person and the non-disabled person. While membership

of the former category depends on having or being perceived to have some trait which falls short of prevailing ability norms, such traits are often acquired over the life-course with the result that individuals may well spend much of their life in each of the categories. The boundaries of these categories are neither fixed nor unchanging, but dependent upon the notion of 'impairment', which is itself a malleable social construction, as well as upon issues of identity and engagement in activism.

By producing these concepts and categories, the social model operates to bring together people with a range of body/mind traits deviating from societal ability norms, to form a disabled people's social movement. Solidarity, or belonging, is generated by a shared experience of disablement through exclusionary societal structures, attitudes and practices and by a shared commitment to resistance and social change.

This operation of the social model was evident in the drafting of the CRPD. Its most obvious manifestation was in the AHC debates where the social model was used to ensure solidarity between people with different impairments through resisting the incorporation of impairment-based distinctions in the new treaty – distinctions which might have had the potential to reduce the standard of rights protection afforded to people with certain impairment types (for instance, those with psychosocial or intellectual impairments).[163] The operation of the social model to produce the concepts and categories outlined above is also evident in the way in which it was used in the AHC debates about the guidance that the CRPD should provide on the meaning of 'disability'- guidance set out most clearly in paragraph (e) of the CRPD's preamble.[164] At a higher level, it might also be argued that the social model's production of 'disability' as a form of injustice helps to explain why it provided an underpinning point of reference in the AHC discussions.[165] Indeed, this function of the social model also played an important role in generating the political impetus behind the demand for a disability-specific human rights convention.

Second, as a technology of sign systems, Beckett and Campbell argue that the social model delineates the type of statement and practice that have come to be associated with emancipatory disability politics.[166] Examples include 'nothing about us without us', 'rights not charity', and 'accessibility and inclusion'. It also provides a basis from which to challenge statements and practices which run in a contrary direction, such as claims that 'biology is destiny'; practices which segregate disabled people, in educational, employment and other settings; or practices which privilege the expertise of medical or other professionals over the life choices of the individual disabled person concerned.

Examples of how the social model operated in this way in the AHC discussions can again be identified – particularly in the context of what was described earlier as the model's use to promote equality and inclusion.[167] It was employed to support arguments against segregated education, for example. It was also used, in the contexts of deprivation of liberty and legal capacity, to challenge any framing of the new treaty which would permit restrictions of liberty or legal capacity simply on the basis of a medical diagnosis of a particular impairment. It was thereby used to challenge the privileging of the expertise of medical professionals over individual autonomy and agency.

Interestingly, the published AHC documents do not suggest that explicit reference was made to the social model in connection with arguments that the CRPD should include requirements that governments and others involve and consult disabled people in relevant decision-making processes.[168] This is despite the fact that the phrase 'nothing about us

without us' was commonly cited in the negotiations and used to influence the accessibility and inclusiveness of the UN facilities and systems in and through which they took place.[169] This phrase is closely associated with and, we suggest, delineated by the social model, the process implications of which are sometimes neglected in favour of debates about its substantive implications. This point is also made by Samaha, who explains that 'the social model can influence institutional choices by shifting the demand for expertise'[170] - because framing a problem as one of tackling disadvantage or exclusion necessarily requires different institutional expertise than would be required to address a problem framed in terms of finding medical or technological solutions.

Finally, as a technology of the self, the social model allows disabled people 'to work upon themselves, ... through the transformation of their bodies via the expulsion of the personal tragedy narrative'[171] and the rejection of such labels as deficient, defective, invalid or pitiable. It thus allows them to invent themselves anew as members of an oppressed group - disabled people - and to call for liberation and social change.

It is not easy to identify explicit examples of this operation of the social model in the AHC negotiations. To the extent that it involves an outward focus on social change, however, it underpins the use made of the social model to support arguments for equality and inclusion.[172] More broadly, this operation of the social model undoubtedly contributed to the development of disabled people's movements around the world and thus helped to generate the climate and the collective resource to nurture and shape the CRPD. The following passage, published some ten years before the adoption of the CRPD, remains one of the most powerful publicly available accounts of the impact of the social model on self-image and esteem:

> My life has two phases: before the social model of disability, and after it. Discovering this way of thinking about my experiences was the proverbial raft in stormy seas. It gave me an understanding of my life, shared with thousands, even millions, of other people around the world, and I clung to it. It has been my mainstay, as it has been for the wider disabled people's movement ... . It has played a central role in promoting disabled people's individual self-worth, collective identity and political organisation. I don't think it is an exaggeration to say that the social model has saved lives.[173]

The different operations of the social model outlined here do not function in isolation. At a foundational level, they work together to provide the basis for the 'new collective'[174] of disabled people and the framing of a social movement. In the words of a leading UK dis- ability activist:

> Despite the artificial nature of the label 'disabled', this shared experience of external barriers allows disabled people, irrespective of their different impairments, to feel a sense of shared identity. ... [T]he social model has offered a valuable and effective tool for helping people, disabled and non-disabled alike, to view disability in a way that does not put the 'blame' for disability on the disabled person.[175]

As Beckett and Campbell suggest,[176] such operations of the social model reflect its role as an oppositional device, representing and facilitating disabled people's resistance to disciplinary practices and technologies which produce or regulate the marginalisation, categorisation and subjectivation of people with impairments. In important respects therefore, it operates to resist machineries of government and associated technologies of discipline.[177]

4.2.3. The human rights model

The human rights model can be regarded as a concrete operation of the same three of Foucault's technology types as the social model, although it operates in different ways and with different outcomes. In addition, as explained below, it operates as a technology of disci- pline. In the discussion which follows, we will draw brief comparisons with the social model where this enhances clarity and, where relevant, we will support arguments with references to how the human rights model has been used in the CRPD Committee's con- cluding observations (discussed in Section 2 above).

First, as a technology of production, the human rights model produces rights-holders. It also produces the categories of rights-respecting and rights-violating States and institutions. In the interests of clarity, it should be stressed that membership of these categories is not static or fixed – it will vary depending on which element of which particular right is considered; and will continuously change over time.

Through these concepts and categories, the human rights model operates to bring disabled people together with other human beings as part of a wider human rights movement. Solidarity, or belonging, is generated by a shared sense of humanity and a shared commitment to positive social change to enable individual flourishing based on respect for human difference and individual dignity. The human rights model and the social model are thus characterised by different claims to belonging – the former being focused primarily on belonging to the human race and the latter on belonging to the political category of disabled people.

This productive operation of the human rights model is reflected, to some extent, in the references made to it in the CRPD Committee's concluding observations. The most obvious example is its use in connection with the importance of initiatives to raise awareness of the status of disabled people as rights-holders and the implications of acknowledging and respecting this status.[178]

Second, as a technology of sign systems, the human rights model delineates the type of statement and practice associated with a human rights approach to disability policy. It sets out standards of behaviour expected of States and institutions to ensure basic social justice for disabled people and it creates and provides guidance on practices and procedures for monitoring progress in rights-implementation. It also provides a basis from which to challenge statements and practices which run in a contrary direction. It is, for instance, not uncommon for concluding observations to contrast the recommended human rights model approach with alternative approaches which they label as 'medical model'[179] or some other type of problematic model (e.g. 'charity model',[180] institutionalization model'[181] or 'special education model').[182]

It is by operating as a technology of this type, in particular, that the human rights model is able to offer what Degener describes as a 'roadmap' for change. The level of guidance as to policy and practice offered by the human rights model is certainly much more detailed than that offered by the social model – although the articulation of rights and obligations in the CRPD, like all human rights treaties, of course leaves room for national variation and different implementation strategies and practices.

Third, as a technology of the self, the human rights model allows disabled people to work on themselves. It engenders a sense of self-respect and self-worth – a sense of being a person who is as valuable as any other human being; of being somebody whose choices and preferences matter; and who has rights to be included in community life

and participate in education, employment, leisure and family life. Like the social model therefore, the human rights model operates in ways that can be profoundly empowering at an individual level.

Finally, in relation to technologies of discipline, the human rights model (like the social model) can be characterised as an oppositional device operating to challenge technologies of government which marginalise, disadvantage and disempower disabled people. In addition, through its codification in the CRPD and via the CRPD's national and international monitoring mechanisms, the human rights model can be understood to operate as a technology of discipline. Discipline, in the Foucauldian sense, denotes the techniques through which an undesirable state can be corrected and desirable behaviour ensured. It is not merely a manifestation of repressive power. It also encompasses subtle means through which norms and expected behaviours are inculcated and adopted by governments, other institutions and organisations and individuals. Key to technologies of discipline is procedural codification, surveillance, examination, and mechanisms of reward or punishment. The particular systems, at international and national levels, set up to oversee the appropriate implementation of the CRPD, can be viewed as examples of the operation of such technologies.

The CRPD, and its accompanying Optional Protocol, provide the basis for the establishment and functioning of the CRPD Committee as part of an international framework for monitoring how well States are implementing CRPD rights and to provide guidance to enhance understanding and effectiveness. Indeed the CRPD Committee's concluding observations are themselves part of this international monitoring process and as such contribute to the delineation of relevant standards. Such observations include praise for States, in the form of complements for particular strategies or innovations which cohere with the CRPD and thus the human rights model; as well as criticism for regressive developments or inaction. While the CRPD Committee does not have power to 'punish' States through the imposition of sanctions, the reputational implications of public criticism from such a body has the potential to damage the standing of governments both internationally and at home.

Examples of how the human rights model operates as a technology of discipline can also be found at the national level. Particularly significant in this regard are the mechanisms the CRPD requires States parties to establish in order to co-ordinate the implementation of the treaty and to monitor progress. Also relevant, particularly in countries with monist approaches to international law, is the use that can be made of the CRPD in courts.[183]

4.3. Complementarity of the models

The human rights model of disability policy and the social model of disability have much in common. They are both shaped by and make possible resistance by disabled people and their allies to oppressive and exclusionary socio-political systems and practices. They thus work toward the same broad end – but in specific ways, consistent with key differences in the nature of the models. Most fundamentally, the human rights model is a model of disability policy, whereas the social model is a model of disability. The subject-matter and focus of each is therefore distinct. Each model also operates differently.

Close analysis of how the two models operate, of the kind carried out above, makes it clear that it would be misleading to regard the human rights model as generally superseding or improving upon the social model. Instead, the models should be understood as performing distinct functions and as working together in ways that are complementary. Two points can be made in support of this view:

First, as discussed above in relation to technologies of sign systems and discipline, the human rights model operates to support the development of particular types of law and policy, together with particular governmental and intergovernmental structures and mechanisms for overseeing and monitoring their implementation. By contrast, the social model is more open textured. It operates in connection with emancipatory disability politics more generally. As the analysis of the AHC debates in Section 2 above makes clear, it can and has been used in connection with emancipatory disability politics focusing on human rights policies and frameworks. However, it is not confined to the human rights setting and can operate in contexts where claims and campaigning objectives are differently framed. In this sense, the human rights model is narrower in scope and less flexible than the social model. This means that the social model will operate in some con- texts where the human rights model does not operate to make possible disabled people's resistance to disabling systems and practices.

Second, the two models are complementary in that, in important respects, the operation of the human rights model is dependent on the social model. A key element of the CRPD and therefore the human rights model is the involvement of disabled people's organisations in the elaboration of disability-related policies, practices and procedures.[184] As is evident from the discussion above, it is the operation of the social model as a technology of production and a technology of the self that makes possible the formation of disabled people's organisations which bring together people with different impairment types to resist disablement. The solidarity engendered by the social model is primarily between people with different types of impairment, to create a sense of belonging to the collective of disabled people. This contrasts with the solidarity engendered by the human rights model, which is primarily between disabled people and all others, to create a sense of belonging to the human race. It is the social model, not the human rights model, which brings disabled people together to form representative multi-impairment organisations. Without it, whilst there might be impairment- specific organisations, umbrella and other multi-impairment organisations of disabled people would be much fewer in number and not well placed to carry out the important roles envisaged for them by the CRPD and the human rights model. The importance of such representative organisations to the CRPD is unsurprising given the significant role they played in the AHC's drafting of the treaty,[185] and is highlighted and explained in the CRPD Committee's General Comment No 7, as well as in provisions of the CRPD itself.[186]

5. Conclusion

Disability models, particularly the social model of disability, have been pivotal in the history of disabled people's political mobilisation, the formulation of disability-related law and policy and the development of interdisciplinary Disability Studies. The human rights model has gained prominence and considerable influence, particularly in law and policy

contexts, since the adoption of the CRPD in 2006. The analysis we have conducted examines the relationship between the social model and the human rights model and offers an alternative to the prevailing view that the latter supersedes or improves upon the former.

Our discursive analysis of the use made of each of the models in the drafting and monitoring of the CRPD provides context and examples for our detailed comparison of the nature and functions of the models. On the basis of this examination, we found reason to question the validity of many contrasts which previous work draws between the two models and uses to provide the basis of the 'improvement thesis'. Our own comparison between the models endorses two of Degener's distinctions and identifies other important differences - including the fact that the subject-matter of the social model is disability, whereas the subject-matter of the human rights model is disability policy.

Both the human rights model of disability policy and the social model of disability operate as oppositional devices, formed by and at the same time making possible disabled people's resistance to unjust disabling societies. Both operate, in different ways, as technologies of production, sign system and the self, with the human rights model also operating, in a very particular way, as a technology of discipline. The human rights model builds upon the social model, and complements it. Both models are valuable tools, which skilled operators - be they scholars, disability activists or anyone else striving to achieve equality, participation, inclusion, quality of life and dignity for disabled people - need in their toolbox. It is important to select the best tool for the task. For some purposes, including the monitoring of States' efforts to implement the CRPD, the human rights model may be more appropriate. For other purposes, however, the social model will continue to be better suited.

Clarity about the roles of these two models and the relationship between them is essential to future scholarship in the field of disability and human rights and Disability Studies more generally. The human rights model is important as a model of disability policy. It provides a detailed road map for the development of human-rights-consistent law and policy, as well as systems and frameworks for monitoring progress. The more open-tex- tured social model operates to support emancipatory disability politics in contexts which are not framed by reference to human rights; and continues to be pivotal to the for- mation, amongst people who have impairments, of a resistant subjectivity based upon shared experience of a disabling society. To operate effectively, the human rights model must work alongside the social model. It is therefore complementary to the social model and not an improvement upon it.

Notes

1. M. Oliver, 'A New Model in the Social Work Role in Relation to Disability', in The Handicapped Person: A New Perspective for Social Workers, J. Campling (RADAR, 1981), https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Campling-handicppaed.pdf (accessed October 21, 2019); M. Oliver, Social Work and Disabled People (Macmillan, 1983).
2. Constitution of Disabled People's International', preamble, http://dpi.org/document/documents-of-reference/dpi-constitutionen.pdf (accessed November 26, 2019). Note, however, that the terms 'impairment' and 'disability' are not used to describe these ideas in the same way as by UPIAS. See further, D. Driedger, The Last Civil Rights Movement: Disabled Peoples' International (Hurst & Co, 1989), ch 5.
3. 'Union of Physically Impaired Against Segregation/Disability Alliance: Fundamental Principles of Disability', (UPIAS/Disability Alliance, 1976), p. 3.

4. Oliver, 'A New Model' (n 1), pp. 31-32 of the online document.

5. M. Oliver, 'The Individual and Social Models of Disability' (paper presented at Joint Work-shop of the Living Options Group and the Research Unit of the Royal College of Physicians on People with Established Locomotor Disabilities in Hospitals, 1990), p. 3. https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Oliver-in-soc-dis.pdf (accessed October 6, 2019).

6. That there are multiple social models of disability has long been recognised. See e.g. G. Dewsbury et al., 'The Anti-Social Model of Disability', *Disability & Society* 19, no. 2 (2004): 145; T. Shakespeare and N. Watson, 'The Social Model of Disability: An Outdated Ideology?', Research in Social Science and Disability 2 (2002): 9; C. Thomas, 'Developing the Social Relational in the Social Model of Disability: A Theoretical Agenda', in *Implementing the Social Model of Disability: Theory and Research*, eds. C Barnes and G Mercer (Disability Press, 2004).

7. A point discussed more fully in J. Grue, Disability and Discourse Analysis (Ashgate, 2016).

8. J. Miller, 'The European Disability Rights Revolution', European Law Review 44, no. 1 (2019): 66, 69.

9. G. Quinn and T. Degener, 'The Moral Authority for Change: Human Rights Values and the World Wide Process of Disability Reform', in Human Rights and Disability: The Current Use and Future Potential of Human Rights Instruments in the Context of Disability, eds. G. Quinn and T. Degener (United Nations, 2002), 13, 14.

10. A. S. Kanter, 'The Globalisation of Disability Rights Law', Syracuse Journal of International Law and Commerce 30 (2003): 241, 247 in fn 23.

11. See in particular, T. Degener, 'Disability in a Human Rights Context', Laws 5, no. 3 (2016): 35; T. Degener, 'A New Human Rights Model of Disability', in The United Nations Convention on the Rights of Persons with Disabilities: A Commentary, eds. V. Della Fina, R. Cera, and J. Palmisano (Springer, 2017), 41; T. Degener, 'A Human Rights Model of Disability', in Routledge Handbook on Disability Law and Human Rights, eds. P. Blanck and E. Flynn (Routledge, 2017), 31. See also M. A. Stein and P. J. Stein, 'Beyond Disability Civil Rights', Hastings Law Journal 58 (2007): 1203 at 1209-10, although they refer to a 'disability human rights paradigm' rather than a 'human rights model of disability'; S. Arduin, 'Article 3. General Principles', in The UN Convention on the Rights of Persons with Disabilities: A Commentary, eds. I. Bantekas, M. Stein and D. Anastasiou (OUP, 2018) (particularly at 98-99); S. Arduin, 'Implementing Disability Rights in Education in Ireland: An Impossible Task?' Dublin University Law Journal 36 (2013): 93.

12. A/Res/61/106, adopted on 13 December 2006.

13. The growing influence of this view is noted e.g. by E. Kakoullis and Y. Ikehara in 'Article 1. Purpose' in Bantekas, Stein and Anastasiou (n 11) at 38 and 58-59.

14. G. Bowen, 'Document Analysis as a Qualitative Research Method', Qualitative Research Journal 9, no. 2 (2009): 27.

15. GA/Res/56/168 (19 December 2001) 61st item 76.67(b). During our analysis, the online archive of this Committee's work was available at https://www.un.org/development/desa/disabilities/resources/ad-hoc-committee-on-a-comprehensive-and-integral-international-convention-on-the-protection-and-promotion-of-the-rights-and-dignity-of-persons-with-disabilities.html (accessed November 7, 2019). Unfortunately, however, these documents have subsequently been taken off line but the authors have retained copies.

16. See e.g. M. Foucault, *The Order of Things* (Pantheon Books, 1970); *The Archaeology of Knowledge* (Trans, 1969).

17. For examples of other work which has analysed the way different models of disability operate discursively, see M. Oliver, 'Politics and Language: Understanding the Disability Discourse' (1994). https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Oliver-pol- and-lang-94.pdf (accessed November 28, 2019); J. Haegele and S. Hodge, 'Disability Dis- course: Overview and Critiques of the Medical and Social Models', *Quest* 68, no. 2 (2016) 193; B. Manago, D. Davis, and C. Goar, 'Discourse in Action: Parents' Use of Medical and Social Models to Resist Disability Stigma', *Social Science and Medicine* 184 (2017): 169.

18. R. Kayess and P. French, 'Out of Darkness into Light: Introducing the United Nations Convention on the Rights of Persons with Disabilities' Human Rights Law Review 1 (2008): 1. 7.
19. R. Traustadóttir, 'Disability Studies, the Social Model and Legal Developments', in The UN Convention on the Rights of Persons with Disabilities - European and Scandinavian Perspectives, eds. O. Arnardóttir and G. Quinn (Martinus Nijhoff, 2009), 3, 16.
20. T. Degener, 'Disability in a Human Rights Context' (n 11), 48.
21. A point also acknowledged by Kayess and French (n 18), who refer to it as a 'populist' version of the social model; and Harper in P. Harper, 'Embracing the New Disability Rights Paradigm: The Importance of the Convention on the Rights of Persons with Disabilities', Disability and Society 27, no. 1 (2012): 1, who refers to it as a 'non-radical' version of the model.
22. 'Report of the Ad Hoc Committee Promotion of the Rights and Dignity of Persons with Disabilities' Second Session, A/58/118 & Corr 1 (3 July 2003), (on file with the authors), Annex II.
23. Rehabilitation International, 'UN Convention on the Human Rights of People with Disabilities: Ad Hoc Committee Seventh Session - Daily Summaries' (on file with the authors), 24 January 2006.
24. Ibid.
25. 'Report of the Third Session of 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', A/AC265/2004/5 (9 June 2004) (on file with the authors), Annex II (Article 2: General Principles).
26. Land Mine Survivors Network, 'Daily Summary of Discussion at the Third Session', (on file with the authors) 24 May 2004.
27. 'Compilation of Proposals Received from Government Delegations' submitted to the Eighth Session of the Ad Hoc Committee (on file with the authors), p 3.
28. Disabled People's International, 'UN Convention on the Human Rights of People with Disabilities: Ad Hoc Committee Eighth Session - Daily Update' (on file with the authors) 21 August 2006.
29. See e.g. Disabled Peoples' International, Handicap International and the International Service for Human Rights, 'UN Convention on the Human Rights of People with Disabilities: Ad Hoc Committee Fourth Session - Daily Summaries 23 August 2004' (on file with the authors); Rehabilitation International (n 23), 31 January 2006; and Disabled People's International (n 28), 23 August 2006.
30. 'Report of the Third Session of the Ad Hoc Committee' (n 25), Annex II, footnote 12.
31. Disabled Peoples' International, Handicap International and the International Service for Human Rights (n 29), 23 August 2004.
32. Ibid.
33. Ibid.
34. Rehabilitation International (n 23), 31 January 2006 - although Israel indicated that it would prefer the phrase 'persons with disabilities' to be defined instead of the phrase 'disability'.
35. Disabled Peoples' International, Handicap International and the International Service for Human Rights (n 29), 23 August 2004.
36. Rehabilitation International (n 23), 31 January 2006.
37. Ibid.
38. Ibid.
39. Disabled Peoples' International, Handicap International and the International Service for Human Rights (n 29), 23 August 2004.
40. Ibid.
41. Ibid.
42. Rehabilitation International (n 23), 31 January 2006.
43. Ibid.
44. World Health Organisation, 'The International Classification of Functioning, Disability and Health', (paper submitted to the Ad Hoc Committee's Eighth Session in 'Contributions from UN System Agencies') (on file with the authors), Tenet 6.

45. 'Joint Statement on an UN Convention on the Rights and Dignity of Persons with Disabilities', adopted at the UNESCAP Workshop on Regional Follow-up to the Seventh Session and Preparation for the Eighth Session of the Ad Hoc Committee on an International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities (21 July 2006), paper submitted to the Ad Hoc Committee's Eighth Session in 'Contributions from UN System Agencies' (on file with the authors) para 4(a) (footnotes omitted).
46. Disabled Peoples' International, Handicap International and the International Service for Human Rights (n 29), 23 August 2004.
47. 'Proposed Modifications by Governments' paper submitted to Ad Hoc Committee Seventh Session (on file with the authors).
48. Rehabilitation International (n 23), 31 January 2006.
49. Ibid.
50. Ibid.
51. For careful analyses of all the AHC discussions relevant to the CRPD's guidance on the concept of 'disability (not confined, as the present discussion, to documents explicitly mentioning the social model) see, on para (e) of the preamble, J. Lord, 'Preamble' and, on Article 1, E. Kakoullis and Y. Ikehara, 'Article 1: Purpose' – both chapters in Bantekas, Stein and Anastasiou (n 11).
52. See e.g. T. Titchkosky, 'Disability: A Rose by Any Other Name? 'People-First' Language in Canadian Society', Canadian Review of Sociology and Anthropology 38 (2001) 125.
53. For this reason, the term 'condition' was used instead by the International Disability Caucus in its proposal on Article 2 at the seventh session of the AHC (on file with the authors).
54. See e.g. T. Campbell, Dyslexia: The Government of Reading (Palgrave Macmillan, 2013); F. Kumari Campbell, Contours of Ableism: The Production of Disability and Abledness (Palgrave MacMillan, 2009); G. Wolbring, 'The Politics of Ableism', Development 51, no. 2 (2013): 252.
55. Traustadóttir (n 19), 12-13.
56. Kayess and French (n 18), 21.
57. Land Mine Survivors Network (n 26), 26 May 2004.
58. Rehabilitation International, 'UN Convention on the Human Rights of People with Disabilities. Ad Hoc Committee Fifth Session – Daily Summaries' (on file with the authors), 3 Feb-ruary 2005.
59. Ibid, 25 January 2005.
60. Rehabilitation International (n 23), 24 January 2006.
61. Centre for Studies in Inclusive Education, 'Briefing for the Ad Hoc Committee's Fifth Session' (on file with the authors) at p 1.
62. See e.g. comments by India and Jordan, Land Mine Survivors Network (n 26), 1 June 2004; and Republic of Korea, Rehabilitation International, 'UN Convention on the Human Rights of People with Disabilities: Ad Hoc Committee Sixth Session – Daily Summaries' (on file with the authors), 8 August 2005.
63. Ibid. See also the International Disability Caucus' contribution to this effect in Rehabilitation International (n 23), 25 January 2006.
64. Ibid.
65. Rehabilitation International (n 62), 8 August 2005.
66. Ibid.
67. CRPD, Article 1.
68. See e.g. comments by Thailand and Mexico reported at Rehabilitation International (n 58), 25 January 2005.
69. Rehabilitation International (n 23), 31 January 2006.
70. Land Mine Survivors Network (n 26), 25 May 2004.
71. Ibid, 4 June 2004.
72. Ibid, 2 June 2004, per Disabled People's International.
73. Ibid, 3 June 2004, per World Network of Users and Survivors of Psychiatry.

74. Report of the Third Session (n 25), Annex II (Draft Article 5: Promotion of Positive Attitudes) – proposal introduced by the Philippines.
75. Disabled Peoples' International, Handicap International and the International Service for Human Rights (n 70), 1 September 2004.
76. Ibid.
77. CRPD, preamble paragraph (e).
78. For detailed analysis, see e.g. D. Anastasiou, M. Gregory, and J. M. Kauffman, 'Article 24: Education' in Bantekas, Stein and Anastasiou (n 11), 656; V Della Fina, 'Article 24 [Education]', in Della Fina, Cera and Palmisano (n 11), 439; and G de Beco, 'The Right to Inclusive Education According to Article 24 of the UN Convention on the Rights of Persons with Disabilities: Background, Requirements and (Remaining) Questions', *Netherlands Quarterly of Human Rights* 32, no. 3 (2014): 263.
79. Stein and Stein (n 11), 1240.
80. Degener, 'A Human Rights Model of Disability' (n 11), 33.
81. CRPD Committee, Concluding Observations on Peru, CRPD/C/CO/1 (20 April 2012), para 6.
82. Ibid, para 47.
83. See e.g. Concluding Observations on Oman, CRPD/C/OMN/CO/1 (17 April 2018), para 46 (b); Jordan, CRPD/C/CO/1 (15 May 2017), para 48(b); and Armenia, CRPD/C/ARM/1 (12 April 2017), para 6(b).
84. See e.g. Concluding Observations on Paraguay, CRPD/C/PRY/CO/1 (15 May 2013), para 72; and the Russian Federation, CRPD/C/RUS/CO/1 (9 April 2018), paras 7 and 8.
85. Concluding Observations on Turkmenistan, UN Doc CRPD/C/TKM/CO/1 (17 April 2015), para 10.
86. Concluding Observations on the Seychelles, CRPD/C/SYC/CO/1 (16 April 2016), para 7(c).
87. See e.g. CRPD Committee Concluding Observations on Norway, CRPD/C/NOR/CO/1 (7 May 2019), para 5(d); and the Philippines, CRPD/C/PHL/CO/1 (16 October 2018) para 6(a).
88. CRPD Committee Concluding Observations on Argentina, CRPD/C/ARG/CO/1 (29 September 2012), para 8.
89. e.g. CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1 (15 October 2012) paras 9 and 10; Brazil, CRPD/C/BRA/CO/1 (29 September 2015), paras 6 and 7; and Saudi Arabia, CRPD/C/SAU/CO/1 (13 May 2019) paras 5(b) and 6(a) and (b).
90. e.g. CRPD Committee Concluding Observations on Mongolia, CRPD/C/MNG/CO/1 (16 April 2015), para 8; Croatia, CRPD/C/HRV/CO/1 (17 April 2015), para 5; Qatar, CRPD/C/QAT/CO/1 (2 September 2015), para 7; Gabon, CRPD/C/GAB/CO/1 (2 October 2015), paras 10 and 11; and the United Kingdom, CRPD/C/UK/CO/1 (29 August 2017) paras 6 and 7.
91. e.g., in connection with the 'Comprehensive Legislation on the Protection of the Rights of Persons with Disabilities (2004)' in Iran, CRPD/C/IRN/1 (5 April 2017), para 9; the Equal Opportunities Act and the Training and Employment of Disabled Persons Act in Mauritius, CRPD/C/MUS/CO/1 (30 September 2015), para 6; and the 'envisaged reforms' on disability certification, work capacity and retirement in Bulgaria, CRPD/C/BGR/CO/1 (22 October 2018), para 14.
92. e.g. in its Concluding Observations on the United Arab Emirates, CRPD/C/ARE/CO/1 (22 August 2016), para 7; Morocco, CRPD/C/MAR/CO/1 (25 September 2017), para 6; Slovenia, CRPD/C/SVN/CO/1 (16 April 2018) para 4; Nepal, CRPD/C/NPL/CO/1 (16 April 2018), para 8; and South Africa, CRPD/C/ZAF/CO/1 (23 October 2018), para 5.
93. e.g. in the Committee's Concluding Observations on Montenegro, CRPD/C/MNE/CO/1 (28 August 2017), paras 44 and 49; Latvia, CRPD/C/LVA/CO/1 (10 October 2017), para 7; Algeria, CRPD/C/DZA/CO/1 (27 June 2019), para 7; Norway, (n 118, para 6); and Turkey, CRPD/C/TUR/CO/1 (9 April 2019), para 55.
94. CRPD/C/POL/CO/1 (29 October 2018), para 6(b). See, for the similar passage in the Concluding Observations on Malta, CRPD/C/MLT/CO/1 (17 October 2018), para 6(b).

95. (n 89), para 20. See also, for examples of similar concerns, the Committee's Concluding Observations on Costa Rica, CRPD/C/CRI/CO/1 (12 May 2014) para 17; Mongolia (n 90), para 16; Gabon (n 90), para 21; Nepal (n 92), para 16; Oman (n 83), para 18; the Seychelles (n 86), para 19; Thailand, CRPD/C/THA/CO/1 (11 April 2016), para 20; United Kingdom (n 90), para 23; Algeria (n 93), 18; Malta (n 94), para 14; Norway (n 87), para 14; Philippines (n 87), para 19; South Africa (n 92), para 7; and Vanuatu, CRPD/C/VUT/CO/1 (13 May 2019), para 17.

96. (n 89), para 16.

97. CRPD/C/CAN/CO/1 (12 April 2017), para 20.

98. See e.g. in those on Argentina (n88), para 39; Gabon (n 90), para 55; Lithuania, CRPD/C/LTU/CO/1 (11 May 2016) para 49; Qatar (n 90), para 46; United Arab Emirates (n 92), para 46; Niger, CRPD/C/NER/CO/1 (1 May 2019), para 42; Senegal, CRPD/C/SEN/CO/1 (13 May 2019) para 44; and Bulgaria (n 91), para 52.

99. (n 97), para 10.

100. (n 88), para 20.

101. CRPD/C/AZE/CO/1 (12 May 2014), para 29.

102. CRPD/C/KOR/CO/1 (29 October 2014), para 38.

103. CRPD/C/AUT/CO/1 (30 September 2013), para 30.

104. (n 88), paras 23 and 24.

105. See e.g., the CRPD Committee's Concluding Observations on Bulgaria (n 91), paras 10 and 60; Cuba, CRPD/C/CUB/CO/1 (10 May 2019) para 8; Malta (n 94), para 6; Philippines(n 87), para 7; Poland (n 94), para 6; Senegal (n 98), para 6; and South Africa (n 92), para 5.

106. See e.g. Concluding Observations on Poland (n 94), para 6.

107. See e.g. Concluding Observations on Bulgaria (n 91), para 70.

108. See e.g. Concluding Observations on Norway (n 87), para 14; Philippines (n 87), para 19; and Poland (n 94), para 14.

109. See references at n 11.

110. See e.g. Degener, 'A New Human Rights Model of Disability' (n 11), 36.

111. Ibid, 43 fn 6. See for examples of publications in which the phrase 'human rights model of disability' was used prior to 2014, T. Degener and G. Quinn, 'A Survey of International, Comparative and Regional Disability Law Reform', in *Disability Rights Law and Policy*, eds. M. L. Breslin and S. Yee (Transnational Publishers, 2002), 13 and 40; Kanter (n 10), 242. See also, for examples of publications in which the phrase 'human rights model' was used, in disability-related contexts but without adding the words 'of disability', Quinn and Degener, 'The Moral Authority for Change' (n 9) 14; Stein and Stein (n 11), where particular use is made of the phrase 'disability human rights paradigm' but where the term 'disability human rights model' also appears; A. S. Kanter, 'The United Nations Convention on the Rights of Persons with Disabilities and Its Implications for the Rights of Elderly People under International Law', Georgia State University Law Review 25, no. 3 (2009): 527.

112. Degener, 'A Human Rights Model of Disability' (n 11), 33.

113. Stein and Stein (n 11), 1221.

114. Ibid, 1223.

115. Ibid, 1212.

116. Ibid, 1240.

117. Ibid, 1223 and 1225.

118. Ibid, 1240.

119. Degener, 'Disability in a Human Rights Context' (n 11), 53.

120. Ibid, 36.

121. Ibid.

122. Ibid.

123. Ibid, 35.

124. Ibid, 37.

125. Degener, 'A New Human Rights Model of Disability' (n 11), 54-56; Degener, 'Disability in a Human Rights Context' (n 11), 46-47; Degener, 'A Human Rights Model of Disability', (n 11), 47-48.

126. Degener, 'Disability in a Human Rights Context', (n 11), 38; Degener, 'A Human Rights Model of Disability' (n 11), 35.

127. Stein and Stein (n 11), 1210.

128. Ibid, 1209.

129. M. Oliver, *Understanding Disability. From Theory to Practice* (2nd edin, Palgrave MacMillan, 2009), 52.

130. V. Finkelstein, 'The Social Model Repossessed', transcript of talk at Greater Manchester Coalition of Disabled People, 2001, p 4. Online at: https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/finkelstein-soc-mod-repossessed.pdf (accessed October 28, 2019).

131. Degener, 'A New Human Rights Model of Disability' (n 11), 47. See also Degener, 'Disability in a Human Rights Context' (n 11), 40.

132. Ibid, 47.

133. Shakespeare and Watson (n 6).

134. Ibid, 11.

135. C. Thomas, 'Rescuing a Social Relational Understanding of Disability', *Scandinavian Journal of Disability Research* 6, no. 1 (2004): 22, 28.

136. See e.g. J. Morris, ed., *Encounters with Strangers: Feminism and Disability* (Women's Press, 1996). See also T. Shakespeare, *Disability Rights and Wrongs Revisited* (Routledge, 2014); D. Anastasiou and J. Kauffman, 'The Social Model of Disability: Dichotomy between Impairment and Disability', *Journal of Medicine and Philosophy* 38 (2013): 441.

137. Degener, 'A New Human Rights Model of Disability' (n 11), 47; 'Disability in a Human Rights Context' (n 11), 40.

138. Degener, 'Disability in a Human Rights Context', (n 11), 47.

139. Degener, 'A New Human Rights Model of Disability' (n 11), 49; 'Disability in a Human Rights Context' (n 11), 43.

140. Degener, 'Disability in a Human Rights Context', (n 11), 43.

141. Ibid, 44.

142. See e.g. A. Vernon, 'A Stranger in Many Camps: The Experience of Disabled Black and Ethnic Minority Women', in J. Morris (ed) (n 159), 48; A. Vernon, 'The Dialectics of Multiple Identities and the Disabled People's Movement', *Disability and Society* 14, no. 3 (1999): 385; T. Degener, 'Intersections Between Disability, Race and Gender in Discrimination Law', in *European Union Non-Discrimination Law and Intersectionality. Investigating the Triangle of Racial, Gender and Disability Discrimination*, eds. D. Schiek and A Lawson (Routledge, 2011), 29.

143. Degener, 'A New Human Rights Model of Disability' (n 11), 52; 'Disability in a Human Rights Context', (n 11), 45.

144. CRPD, Article 25(b).

145. M. Oliver, 'The Social Model in Action: If I Had a Hammer', in *Implementing the Social Model of Disability: Theory and Research*, eds. C. Barnes and G. Mercer (Disability Press, 2004), 18, 22.

146. Oliver (n 5), 2.

147. R. Frigg and S. Hartmann, 'Models in Science', in *The Stanford Encyclopedia of Philosophy*, ed. E. N .Zalta (Stanford University, 2018). https://plato.stanford.edu/archives/sum2018/entries/models-science/ (accessed October 21, 2019).

148. M. Berghs, K. Atkin, C. Hatton, and C. Thomas, 'Do Disabled People Need a Stronger Social Model: A Social Model of Human Rights?' *Disability and Society* 34 (2019): 1034.

149. Oliver (n 145), 20.

150. L. C. Hawes, *Pragmatics of Analoguing* (Addison-Wesley, 1975).

151. See e.g. Finkelstein (n 130); Oliver (n 145), 30.

152. Thomas (n 135).

153. R. Light, *Social Model or Unsociable Muddle* (Disability Awareness in Action, undated). http://www.daa.org.uk/index.php?page=social-model-or-unsociable-muddle (accessed April 17, 2019).

154. See A. M. Samaha, 'What Good is the Social Model?' *University of Chicago Law Review* 74 (2007): 1251.

155. Oliver (n 129), 13.

156. Wolbring (n 54).

157. This idea was introduced, in the context of art activism, in B. Holmes, 'The Oppositional Device or Taking Matters into Whose Hands?', in *Taking the Matter into Common Hands: on Contemporary Art and Collaborative Practices*, eds. J Billing, M Lind and L Nilsson (Black Dog, 2007), 35.

158. Holmes (n 157), 37.

159. A. Beckett and T. Campbell, 'The Social Model of Disability as an Oppositional Device', *Disability and Society* 30, no. 2 (2015): 270, 274.

160. Ibid.

161. See e.g. M. Foucault, 'Sex, Power and the Politics of Identity', in *Essential Works of Foucault: Ethics, Subjectivity, Truth: Vol. 1*, ed. P. Rabinow (The New Press, 1997), 163-74; M. Foucault, 'The Ethics of the Concern for Self as a Practice of Freedom' in Rabinow (ibid), 281-301; M. Foucault, *Technologies of the Self: A Seminar with Michel Foucault*, edited by L. H. Martin, H. Gutman, and P. H. Hutton (University of Massachusetts Press, 1988).

162. M. Foucault, '*Technologies of the Self*' (n 161).

163. See Section 2.2.4.

164. See Section 2.2.2.

165. See Section 2.2.1.

166. Beckett and Campbell (n 159), 275.

167. See Section 2.2.3.

168. Such as those now contained in CRPD, Articles 4(3) and 33(3).

169. See e.g. S. Tromel, 'A Personal Perspective on the Drafting History of the United Nations Convention on the Rights of Persons with Disabilities', in *European Yearbook of Disability Law*, eds. G. Quinn and L. Waddington (Intersentia, 2009), 115.

170. Samaha (n 154), 1308.

171. Beckett and Campbell (n 159), 276.

172. Section 2.2.3.

173. L. Crow, 'Including All of Our Lives: Renewing the Social Model of Disability', in ed. J. Morris (n 136), 206, 206-207.

174. Beckett and Campbell (n 159) 278, drawing on A. Negri and J. Revel, 'On the Institution of the Common', in *Toward a Global Autonomous University, Cognitive Labor, the Production of Knowledge, and Exodus from the Education Factory*, eds. The Edu-Factory Collective (Autonomedia, 2009), 172-9, describe this as a new 'we' or a 'common'.

175. Light (n 153).

176. Beckett and Campbell (n 159).

177. We acknowledge that like other oppositional devices it is possible for the social model to be co-opted by machineries of government and for it to be used as part of disciplinary practices and technologies that have disabling effect. See e.g. the UK Government's express commit- ment to the social model in the United Kingdom Initial Report on the Rights of Persons with Disabilities (Stationery Office, 2011), https://www.gov.uk/government/publications/un- convention-on-the-rights-of-persons-with-disabilities-initial-report-on-how-the-uk-is- implementing-it (accessed January 23, 2020) at a time when it was introducing austerity measures with effects on disabled people that were subsequently condemned by the CRPD Committee as extremely damaging and retrogressive - see Committee on the Rights of Persons with Disabilities, 'Report of the Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland Carried out by the Committee Under Article 6 of the Optional Protocol to the Convention' CRPD/C/15/4 (2 September 2016).

178. See Section 3.3.3.

179. See e.g. CRPD Committee Concluding Observations on Algeria (n 93), para 6; Bulgaria (n 91), para 9; Cuba (n 105), para 7; Norway (n 87), para 5; Rwanda, CRPD/C/RWA/CO/1 (3 May 2019) para 5; and South Africa (n 92), para 4.

180. See e.g. CRPD Committee Concluding Observations on Saudi Arabia (n 89), para 5.

181. See e.g. CRPD Committee Concluding Observations on the Philippines (n 87), para 34.

182. Ibid, para 40.

183. For extensive analysis of the ways in which courts in thirteen jurisdictions have used the CRPD, see L. Waddington and A. Lawson, eds., *The UN Convention on the Rights of Persons with Disabilities: A Comparative Analysis of the Role of Courts* (OUP, 2018).

184. See, in particular, Articles 4(3) and 33 of the CRPD; and CRPD Committee, 'General Comment No 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organisations, in the implementation and monitoring of the Convention', CRPD/C/GC/7 (21 September 2018).

185. See Section 2.2 above. See also Tromel (n 169).

186. See references at n 184 above.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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