## \*\*\*Cap K Links Disabilities

#### Adoption of the social model masks oppression and destroys unique communities and worldviews of the disabled continuing a cycle of assimilation

Lang 01 (Dr. Raymond Lang is a Senior Research Associate at the Overseas Development Group of the University of East Anglia, January, 2001, “The Development And Critique Of The Social Model Of Disability” www.ucl.ac.uk/lc-ccr/lccstaff/raymond-lang/DEVELOPMMENT\_AND\_CRITIQUE\_OF\_THE\_SOCIAL\_MODEL\_OF\_D.pdf)

This paper has so far outlined the genesis and subsequent development of the social¶ model of disability, as well as highlighting some of the difficulties that are inherent in its¶ universal application across cultural settings. The social model of disability continues to¶ evolve and develop. John Swain and Sally French (2000), building upon the intellectual¶ work described above, have outlined an “affirmation” model of disability, which seeks¶ to “celebrate the difference” that characterise the lives of disabled people. It is therefore¶ contended that disabled people can be “proud” the fact that they are different from the¶ majority of the population. Swain and French begin their analysis by rejecting the¶ tragedy conception of disability as purported by the medical model. They proceed by¶ maintaining that it is not possible to make a stark distinction between those who are¶ disabled and those who are not, since all people, to some extent have a degree of¶ impairment, but do not necessarily encounter the negative consequences of disability.¶ Those who where spectacles to compensate for low vision are a case in point. Neither¶ can a stark distinction be maintained between those who encounter oppression and¶ those who do not, for it is possible disabled people themselves to be oppressors, by¶ having racist, homophobic or sexist attitudes.¶ They further contend that the social model of disability has clearly shown how¶ contemporary society has oppressed and discriminated against disabled people.¶ However, in contrast the majority of most disability studies theorists, they maintain that¶ the vast majority of disabled people accept the analysis of the social model. They have¶ candidly stated:-¶ “The social model was borne out of the experiences of disabled people, challenging¶ the dominant individual models espoused by non-disabled people. Nevertheless,¶ it is our experience that many non-disabled people readily accept the social model,¶ albeit superficially and at a very basic conceptual level. Non-disabled people can¶ generally accept that a wheelchair-user cannot enter a building because of steps.¶ ... Non-disabled people are much more threatened and challenged by the notion¶ that a wheelchair-user could be pleased and proud of the person he or she is”¶ (Swain J. and French, S. 2000:570).¶ Ascribing to the notion of an affirmative model of disability questions the analysis of¶ early variants of the social model, since it is argued that the adoption of the precepts of¶ the latter does not necessarily result in a non-tragic view of disablement. Swain and¶ French again state:-¶ “While the social model of disability is certainly totally incompatible with the¶ view that disability is a personal tragedy, it can be argued that the social model,¶ in itself, underpinned a non-tragedy view. First, to be a member of an oppressed¶ group within society does not necessarily engender a non-tragic view. There is, for instance, nothing inherently non-tragic about being denied access to¶ buildings. Secondly, the social model disassociates impairment from disability.¶ It, thus, leaves the possibility that even in an ideal world of full civil rights and¶ participative citizenship for disabled people, an impairment could be seen as a¶ personal tragedy” (Swain, J. and French, S. 2000:571).¶ Swain and French further develop their thesis by stating that, in contrast to the tragic¶ view of disablement, the occurrence and onset of an impairment can result in an¶ improvement of the quality of lives an individual disabled person. Examples are given¶ of disabled people being able to “escape” the underlying social oppressive practices and¶ structures that characterise some societies. Thus, disabled people may indeed be¶ liberated from the responsibilities in the realms of sexual relations, responsibility within¶ the domestic household, and may be more attuned to comprehend the oppression¶ encountered by other minority groups.

The action of the state is inherently evil- it prevents the disabled from protesting the system itself

Russell and Malthotra, Faculty of Law University of Ottawa, 2002 (Marta and Ravi, “Capitalism and Disability”, http://socialistregister.com/index.php/srv/article/view/5784)

An important analytical distinction must be made between charitable organizations¶ established for disabled people, sometimes by parents of disabled children,¶ and organizations directly controlled by disabled people. In the former category,¶ the organizations, usually based on a diagnostic category linked to impairment,¶ do not necessarily reflect the views and experiences of disabled people themselves,¶ notwithstanding that they may do occasional work that is beneficial. In fact, the¶ implicit ideological agenda of these paternalistic organizations is that disabled¶ people are unable to advocate on their own behalf.48 Moreover, the fact that their¶ mandate rests on usually arbitrary diagnostic categories places unwarranted¶ emphasis on medical issues and not enough on the barriers imposed by the physical¶ environment and the class system. The resulting fragmentation — splintering¶ disabled people into literally hundreds of different categories — also works to¶ make cross-disability solidarity that much more difficult. Just as importantly, these¶ organizations, like NGOs in other sectors, are often directly tied to the state¶ through funding arrangements. Consequently, they are extremely limited in their¶ ability to criticize government policy, even if they were so inclined, for fear of¶ losing funding and access to decision-makers. In fact, organizations run for¶ disabled people dramatically outnumber those controlled by disabled people, and¶ receive far more generous funding.49 The severe limitations of their politics¶ should come as no surprise, given the questionable and co-opted record of NGOs¶ in all contexts.¶ In sharp contrast, organizations run by disabled people have at least the potential¶ for more radical politics. In the late 1960s, the Independent Living (IL)¶ movement emerged in Berkeley, California, spearheaded by a disabled students’¶ group known as The Rolling Quads. It sought to promote the empowerment of¶ disabled people and focused attention on the structural barriers imposed by the¶ built environment, not on the impairments of individuals. The first Independent¶ Living Centre (ILC), based on the social-political model of disablement, was¶ founded in Berkeley and sought to broaden struggles for empowerment to¶ include students and non-students alike. Within a few years, a network of¶ hundreds of ILCs had sprouted across the United States, as well as a number of¶ other countries including Britain, Canada and Brazil.50¶ The emergence of the IL movement was unquestionably a step forward for the¶ disability rights movement. The shared sense of consciousness fostered by collective¶ action is an important first step in the building of any social movement. By¶ redefining as political issues requiring redress by society at large what had been¶ previously regarded by most people as private troubles (just as the women’s¶ movement had done), the IL movement provided a basis for a vital social movement;¶ 51 and the vitality of the women’s movement, the Black civil rightsmovement, the gay and lesbian movement, the Chicano movement and other¶ new social justice movements created an opening in which the case for eradicating¶ disability oppression could also get a hearing.

Only the alternative provides solvency for the oppressed- the most effective mode of resistance is through the disabled communities themselves

Russell and Malthotra, Faculty of Law University of Ottawa, 2002 (Marta and Ravi, “Capitalism and Disability”, http://socialistregister.com/index.php/srv/article/view/5784)

So how, then, can disability politics help to end capitalist exploitation? While¶ to address this question fully is beyond the scope of this paper we will offer some¶ food for thought. Oliver, for instance, suggests ‘if the game is possessive individualism¶ in a competitive and inegalitarian society, impaired people will¶ inevitably be disadvantaged, no matter how the rules are changed’.75 Finkelstein¶ recognizes that a society may be willing to absorb a portion of its impaired population¶ into the workforce, yet this can have the effect of maintaining and perhaps¶ intensifying the exclusion of the remainder.76 Indeed, former US President¶ Clinton suggested that bringing disabled persons into the workforce could be a¶ tool to fight inflation in a tight labour market.77 Abberley suggests that we¶ abandon the notion that production be at the centre of any new conceptualiza-¶ tion of Utopia: ‘even in a society which did make profound and genuine attempts¶ to integrate impaired people into the world of work, some would still be¶ excluded by their impairment’.78¶ But need the ability to labour in some socially recognized sense be a requirement¶ for full membership in society? In a work-based society, productivism is the¶ ‘normal’ activity. A radical disability perspective could offer great liberatory¶ potential by proposing to abolish this notion and to offer counter-values to those¶ of productivism. Is work the defining quality of our worth? Employability, aptitude¶ for earning money and even work chosen during one’s free time are not, a¶ priori, the measure of what it means to live, to be part of the human race.¶ Moreover, a counter-hegemonic praxis of disability politics, challenging productivism,¶ opens the door to alliances with many other groups who are also¶ marginalized by the imprisoning dictates of a market economy. These include¶ single mothers, welfare recipients, part-time workers, parts of the incarcerated¶ population, and all those unable for various reasons to earn a living wage. Indeed,¶ the fostering of grassroots solidarity amongst those oppressed by productionism¶ can only serve to enrich the disability rights movements themselves and enhance¶ the chances of achieving reformist goals of physical and structural access while¶ pursuing a longer term agenda of economic transformation. After all, what is the¶ alternative? Eugenics, sterilization, euthanasia and the institutionalization of the¶ impaired and others have all been productivist societies’ answers to what to do¶ with the ‘unproductive’. If the goal of social justice is to ensure the dignity of each¶ and every person, then buying into the largely capitalist-induced belief that work¶ equates with self esteem or is a condition for membership of the human race —¶ that people are labourers first and human beings second — only serves to oppress¶ us all.

#### Plan is charity that is used to make the disabled profitable by assimilating them into society to buy more products and produce more goods

Russell and Malthotra, Faculty of Law University of Ottawa, 2002 (Marta and Ravi, “Capitalism and Disability”, http://socialistregister.com/index.php/srv/article/view/5784)

Disabled persons who do not offer a body which will enhance profit-making¶ as labourers are used to shore up US capitalism by other means. Entrepreneurs¶ and rehabilitation specialists have made impaired bodies of use to the economic¶ order by shaping disablement into big business and turning the disabled body¶ into a commodity around which social policies get created or rejected according¶ to their market value.41 The corporate solution to disablement — institutionalization¶ in a nursing home, for instance — evolved from the realization that¶ disabled people could be made to serve profit because public financing guaranteed¶ the revenue (in the USA, Medicaid funds 60% of the cost, Medicare 15%,¶ private insurance 25%). Disabled people are worth more to the Gross Domestic¶ Product when occupying a ‘bed’ than a home. When a single impaired body can¶ generate $30,000 — $82,000 in annual revenues Wall Street counts it as an asset¶ that contributes to companies’ net worth. Despite the efforts of the disability rights movement to de-institutionalize disabled populations and shift policy¶ towards the provision of in-home services, the logic of capital reasserts itself via¶ the recommodification of the disabled body in the home (insofar as public¶ funding permits — with the advent of ‘managed care’, trying to limit costs, there¶ is an increased financial motive to underserve). Corporations have taken an¶ interest in the money-making potential of the in-home services field, and indeed¶ promote the in-home services model as they build their new ‘home-care’¶ empires. As Jim Charlton puts it, ‘the transformation of people into commodities¶ hides their dehumanization and exploitation by other human beings: it¶ becomes simply an economic fact of life’.42¶ It is also evident that the definition of disability is not static but fundamentally¶ linked to the needs of capital accumulation. Hence, when the welfare state¶ entered into ‘crisis’, governments attempted to narrow the definition of disablement¶ and to cut entitlement levels. There have also been widespread closures of¶ the institutions that warehoused disabled people, but without an allocation of¶ adequate resources and services to enable them to live independently. Yet this¶ withdrawal of the state from certain types of benefits does not entail any rupture¶ in the intervention of the state in the lives of disabled people. The state’s interventionist¶ role remains but is refocused on the ruthless cutting of social¶ expenditures, including services and income support programmes to disabled¶ people, in the name of neoliberal efficiency.43¶ The rise of capitalism has thus seen dramatic changes in the ideological classification¶ and treatment of disabled people. Yet while socialists have considered the¶ relationship between the rise of capitalism and, for instance, the enactment of the¶ English Poor Laws,44 the classification, marginalization and oppression of disabled¶ people have been largely ignored. Speaking generally, the rise of capitalism clearly¶ had contradictory outcomes for disabled people. On the one hand, there were¶ positive effects in terms of better medical technology that lengthened the life span¶ and increased the quality of life for those who could afford it. On the other hand¶ there were some very negative effects, including classification into rigid and arbitrary¶ diagnostic categories and incarceration in oppressive institutions. Exclusion¶ from exploitation in the wage-labour system, as the ‘deserving poor’, lies at the¶ core of disabled peoples’ oppression in every aspect of modern life.

Case (Generic)

They have NO evidence that providing universal access to public transportation can solve for all of ableism or completely break down the medical model. They only have 2 cards in the context of transportation, which themselves lists several alt causes to lack of access that the aff can’t solve for including economic, fear-based, and time-based exclusions. Means they can’t claim to solve the root cause of conflicts.

And, here’re more alt causes to disabled persons’ lack of participation in their communities

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WHO’s latest conceptualisation of disablement constitutes a substantive improvement upon the previous classification, for it attempts to take the social dimensions of disablement fully into account, indicating a movement along the continuum from a medical to a social understand of disablement. It is also aware of the cultural and material factors which sometimes have a significant bearing upon a particular individual’s ability to participate in contemporary society. Thus, the new classification recognises that poverty, the lack of adequate housing, or inferior environmental factors such as inadequate sanitation, as well as the gender status of a disabled individual, may well affect their ability to participate in contemporary society.

The affirmative has NO impact – their causality claims are false. Their Elden evidence claims that *racism* is the root cause of conflicts and part of modern racism has included medical justifications but NOT that the medical model is the cause of anything – abolishing it *will not* solve.

The aff’s refusal to recognize that there are inherent differences between disabled persons alienates the people they try to help – dooming solvency

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We have already cited the work of feminist commentators arguing that the social model has traditionally either avoided or excluded the issue of impairment. As French suggested above, this seems mainly to have been for reasons of radical rhetoric. It sounds 11 much better to say ‘people are disabled by society, not by their bodies’ than to say ‘people are disabled by society as well as by their bodies’. But the result is that impairment is completely bracketed, just as sexual difference was the taboo subject for the women’s movement in the early 1970s. In properly rejecting the causal role of the body in explaining oppression, disabled radicals have followed their feminist precursors in denying difference entirely: after all, “Once feminists admit the mildest degree of sexual difference, they open up a gap through which the currents of reaction will flow. Once let slip that pre-menstrual tension interfered with concentration, that pregnancy can be exhausting, that motherhood is absorbing, and you are off down the slope to separate spheres.” (Ann Phillips, quoted in Cockburn, 1991, 161). We argue that the denial of difference is as big a problem for disability studies, as it was for feminism. Experientially, impairment is salient to many. As disabled feminists have argued, impairment is part of our daily personal experience, and cannot be ignored in our social theory or our political strategy. Politically, if our analysis does not include impairment, disabled people may be reluctant to identify with the disability movement, and commentators may reject our arguments as being ‘idealistic’ and ungrounded. We are not just disabled people, we are also people with impairments, and to pretend otherwise is to ignore a major part of our biographies. As Linda Birke argued in the case of gender, “Feminist theory needs to take into account not only the ways in which our biology is interpreted, but also the very real ways in which biology does in practice affect our lives.” (Birke, 1986, 47) 12

Don’t buy the aff’s ethical obligation claims – they would just mean that the affirmative would always win because they speak first and can state an uncontroversial claim like racism is bad and then claim that they should win because they brought this issue into debate. You only vote aff is they can defend the solvency of their plan against our arguments.

The complete adoption of their social model would encourage never taking any safety precautions and leading wildly reckless lives

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If the social model argument was pushed to its logical extreme, we might not see impairment as something which we should make efforts to avoid. As a consequence, we might be unconcerned about road safety, gun control, inoculation programmes, and mine-clearance. Of course, no activist in practice actually makes such arguments. However, both British advocates of the ‘strong’ social model and some American minority group approaches seem sometimes to suggest that having more disabled people is by no means a bad thing, and that we should not always try to avoid impairment.

The aff can’t break down the medical model – it’s grounded in the medical field – not transportation.

Ext. Social Model = Exlusion

The affirmative’s focus on society as being the source of disabled people’s problems results in the exclusion of anyone who recognizes their physical limitations

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We argue that the very success of the social model is now its main weakness. Because it is such a powerful tool, and because it was so central to the disability movement, it became a sacred cow, an ideology which could not easily be challenged. Part of its effectiveness arose from its simplicity. It could be reduced to a 6 slogan: ‘disabled by society not by our bodies’. Organisations and policies could be easily evaluated: did they use the (social model) term ‘disabled people’ or did they use the (medical model) term ‘people with disabilities’? Did they focus on barrier removal, or did they focus on medical intervention and rehabilitation? The social model could be used to view the world in black and white, even if this was not the intention of those who originally framed it. Psychologically, people’s commitment to the social model was based on the way it had transformed their self-esteem. Any individual who had become an activist on the basis of joining a collective united by the social model ideology had a deep investment in the social model definition of disability. ‘We’ were oppressed: ‘they’ were oppressors. ‘We’ talk about disability, we don’t mention impairment. You can’t be a proper activist, unless you accept the social model as your creed. This reading of the history of the British disability movement will be contested by some. We are in danger of constructing a ‘straw person’, it will be suggested. After all, no one really takes such an extreme position. The issue of impairment was never really ignored. The social model does not really produce such a rigid dichotomy. But our contention is that many British activists in their public discourse use exactly this ‘strong’ version of the social model that we are critiquing. It may be that in private, their talk is at odds with the ‘strong social model’. Most activists concede that behind closed doors they talk about aches and pains and urinary tract infections, even while they deny any relevance of the body while they are out campaigning. Yet this inconsistency is surely wrong: if the rhetoric says one thing, while everyone behaves 7 privately in a more complex way, then perhaps it is time to reexamine the rhetoric and speak more honestly. Within academia, while some of the leading exponents of the social model now claim to operate a less rigid approach, they still simultaneously reinforce the ‘strong’ social model. For example, Mike Oliver (1996, 34) supplies a table in which two columns list the differences between the ‘individual model’ and the ‘social model’. In the first column, we find words such as ‘medicalisation’, ‘adjustment’, ‘prejudice’, ‘attitudes’, ‘care’, policy’ etc, and in the second column we find the alternatives: ‘self-help’, ‘affirmation’, ‘discrimination’, ‘behaviour’, ‘rights’, ‘politics’. Oliver’s commentary genuflects to the need for flexibility: “It should be noted that, like all tables, this one oversimplifies a complex reality and each item should be seen as the polar end of a continuum.” (Oliver, 1996, 33) before immediately reinforcing the social model dichotomy: “Nevertheless, underpinning [the table] is the same fundamental distinction between impairment and disability as defined by UPIAS…” (Oliver, 1996, 33). Jenny Morris’ very popular and influential book, Pride Against Prejudice (1991) blurred the distinction between impairment and disability in several ways: she discussed the role of impairment and personal experience in the lives of disabled people; she talked about cultural representation; and she used terminology inconsistently, sometimes talking about ‘disability’ when in strictly social model terms she was talking about impairment. For these reasons, her work was regarded by some in the British disability movement as ‘ideologically doubtful’. This 8 tendency, to evaluate ideas on the basis of their conformity to social model orthodoxy, can be seen regularly in the pages of the international journal Disability and Society. For example, recent reviews by Colin Barnes (1998, 1999) of books by American disability scholars have strongly criticised such perspectives because they ignore British disability studies work, and particularly because they fail to adhere to the social model definition of disability. Barnes writes: “… most American and Canadian accounts are impairment specific in that they limit their discussions to ‘people with physical disabilities’ or the body; ‘disability’ is both biological condition and a social construct, and the terms ‘disabled people’ and ‘people with disabilities’ are used interchangeably. As Mike Oliver has repeatedly made clear, this is about far more than simply ‘political correctness’. It’s about the crucial issue of causality, the role of language, its normalising tendencies and the politicisation of the process of definition.” (Barnes, 1999, 578) Carol Thomas has discussed the way that some disability studies academics police writing on disability, in order to exclude anything which does not comply with the social model approach (Thomas, 1998). We argue that similar processes occur within activism: for example, impairment-based organisations are viewed as problematic (e.g. Hurst, 1995). The recent UK government campaign ‘See the person [not the disability]’ was opposed by activists largely because it used the term ‘disability’ to refer to physical impairment (e.g. Findlay, 1999, 7). While we do not believe that ‘See the Person’ was an adequate response to the poverty and exclusion of disabled people, nor do we believe that the main problem with the UK government’s approach to disability 9 is about terminology, which is the impression that the disability movement is in danger of presenting.

Universal Design Impossible

It is impossible to create a barrier free environment

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Of course, some impairment/disability distinctions are straightforward. If architects include steps in a building, it clearly disadvantages wheelchair users. If there is no sign language interpreter, deaf people are excluded. Yet, it could be suggested that the ‘barrier free environment’ is an unsustainable myth (a fairy tale, such as in Finkelstein, 1981). For a start, removing environmental obstacles for someone with one impairment may well generate obstacles for someone with another impairment. It is impossible to remove all the obstacles to people with impairment, because some of them are inextricable aspects of impairment, not generated by the environment. If someone has an 18 impairment which causes constant pain, how can the social environment be implicated? If someone has a significant intellectual limitation, how can society be altered to make this irrelevant to employment opportunities, for example? Does mainstream sport disable impaired athletes by imposing oppressive criteria – such as being able to run to play football?. Some of these examples may seem ridiculous. But they point to the problem of pushing the social model to its implications, and highlight a flaw in the whole conception.

Medical Model Good

The medical model is empirically effective at improving people’s quality of life

The Mind Organization 12 (2/12/10, “Is the Medical Model Really so Evil?” www.mind.org.uk/blog/2943\_is\_the\_medical\_model\_really\_so\_evil)

Even so, I also now think the medical model has its merits as well as its flaws. Diagnostic categories do seem to have some usefulness and validity, and psychiatric medication can at times work wonders. The twentysomething, BA-educated version of me would shake his head in sorrow. So, what's changed my mind on the medical model? Well, the most obvious answer would be that I went into the belly of the beast and trained as a mental health nurse. Certainly cold, hard clinical experience has had a lot to do with it. I can't swan around saying that the drugs don't work, because all too frequently they do work. Admittedly the meds work haphazardly, and sadly all too often with unpleasant side effects, but the bottom line is I've seen too many people benefit from medication to be able to dismiss those benefits. Crucially though, the people who've most effectively challenged my previous hostility to the medical model have been patients rather than doctors. I have a friend with bipolar disorder who's also a very intelligent, independent-minded lady. Not the sort to be brainwashed by an evil cabal of shrinks and Big Pharma. She's tried yoga, mindfulness, CBT, person-centred counselling...all of which have had some benefit, but she's also learned to her cost that, unless she takes the meds, all those benefits are immediately cancelled out. Her response to anti-psychiatry is to angrily insist, "Look, I don't have a problem in living, or a social construct, or an existential crisis. I have an illness which is called bipolar disorder, for which I take medication." "Your diagnosis is this, and we're going to treat it like this" is an explanation that works for a lot of a people. Those people shouldn't be hectored on how they're dupes of the medico-pharmaceutical complex simply for finding the medical model helpful. While much has been written on how psychiatric diagnosis can label and stigmatise people, you can also demean, belittle and patronise people by telling them they don't have an illness, and that it's all just a social construct/problem in living/spiritual crisis.

AT: Dirty Words K

Attempts to censor language make the problem worse – the politically correct surface they create only makes violence easier to swallow

Zizek 99 (Slavoj Zizek, Senior Researcher at the Institute for Social Studies (Ljubljana), 1999, The Ticklish Subject p. 253-4)

Take politically correct probing into hate speech and sexual harassment: the trap into which this effort falls is not only that it makes us aware of (and thus generates) new forms and layers of humiliation and harassment (we learn that 'fat', 'stupid', 'short-sighted'...are to be replaced by 'weight-challenged', etc.); the catch is, rather, that this censoring activity itself, by a kind of devilish dialectical reversal starts to participate in what it purports to censor and fight - is it not immediately evident how, in designating somebody as 'mentally challenged 'instead of'stupid' an ironic distance can always creep in and give rise to an excess of humiliating aggressivity- one adds insult to iniury, as it were, by the supplementary polite patronizing distension (it is well known that aggressivity coated in politeness can be much more painful than directly abusive words, since violence is heightened bv the additional contrast between the aggressive content and the polite surface form ...). In short, what Foucault's account of the discourses that discipline and regulate sexuality leaves out of consideration is the process by means of which the power mechanism itself becomes eroticized, that is, contaminated by what it endeavours to 'repress'. It is not enough to claim that the ascetic Christian subject who, in order to fight temptation, enumerates and categorizes tile various forms of temptation, actually proliferates the object he tries to combat: the point is, rather, to conceive of how the ascetic who flagellates in order to resist temptation finds sexual pleasure in this very act of inflicting wounds on himself.

Censoring words transforms politics into a fight over language rather than focusing on action which can result in real change

Brown 01 (Wendy Brown, professor at UC-Berkeley, 2001 Politics Out of History, p. 35-36)

 “Speech codes kill critique,” Henry Louis Gates remarked in a 1993 essay on hate speech. Although Gates was referring to what happens when hate speech regulations, and the debates about them, usurp the discursive space in which one might have offered a substantive *political* response to bigoted epithets, his point also applies to prohibitions against questioning from within selected political practices or institutions. But turning political questions into moralistic ones—as speech codes of any sort do—not only prohibits certain questions and mandates certain genuflections, it also expresses a profound hostility toward political life insofar as it seeks to preempt argument with a legislative and enforced truth. And the realization of that patently undemocratic desire can only and always convert emancipatory aspirations into reactionary ones. Indeed, it insulates those aspirations from questioning at the very moment that Weberian forces of rationality and bureaucratization are quite likely to be domesticating them from another direction. Here we greet a persistent political paradox: the moralistic defense of critical practices, or of any besieged identity, weakens what it strives to fortify precisely by sequestering those practices from the kind of critical inquiry out of which they were born. Thus Gates might have said, “Speech codes, born of social critique, kill critique.” And, we might add, contemporary identity-based institutions, born of social critique, invariably become conservative as they are forced to essentialize the identity and naturalize the boundaries of what they once grasped as a contingent effect of historically specific social powers. But moralistic reproaches to certain kinds of speech or argument kill critique not only by displacing it with arguments about abstract rights versus identity-bound injuries, but also by configuring political injustice and political righteousness as a problem of remarks, attitude, and speech rather than as a matter of historical, political-economic, and cultural formations of power. Rather than offering analytically substantive accounts of the forces of injustice or injury, they condemn the manifestation of these forces in particular remarks or events. There is, in the inclination to ban (formally or informally) certain utterances and to mandate others, a politics of rhetoric and gesture that itself symptomizes despair over effecting change at more significant levels. As vast quantities of left and liberal attention go to determining what socially marked individuals say, how they are represented, and how many of each kind appear in certain institutions or are appointed to various commissions, the sources that generate racism, poverty, violence against women, and other elements of social injustice remain relatively unarticulated and unaddressed. We are lost as how to address those sources; but rather than examine this loss or disorientation, rather than bear the humiliation of our impotence, we posture as if we were still fighting the big and good fight in our clamor over words and names. Don’t mourn, moralize

**Punishing offensive language makes it worse—censorship only drives it underground where its effects are more acute**

Roskoski and Peabody 91 (Matthew Roskoski and Joe Peabody, 1991, “A Linguistic and Philosophical Critique of Language ‘Arguments’” http://debate.uvm.edu/Library/DebateTheoryLibrary/Roskoski&Peabody-LangCritiques, accessed 10/17/02

If language "arguments" become a dominant trend, debaters will not change their attitudes. Rather they will manifest their attitudes in non-debate contexts. Under these conditions, the debaters will not have the moderating effects of the critic or the other debaters. Simply put, sexism at home or at lunch is worse than sexism in a debate round because in the round there is a critic to provide negative though not punitive feedback. The publicization effects of censorship are well known. "Psychological studies reveal that whenever the government attempts to censor speech, the censored speech - for that very reason - becomes more appealing to many people" (Strossen 559). These studies would suggest that language which is critiqued by language "arguments" becomes more attractive simply because of the critique. Hence language "arguments" are counterproductive. Conclusion Rodney Smolla offered the following insightful assessment of the interaction between offensive language and language "arguments": The battle against {offensive speech} will be fought most effectively through persuasive and creative educational leadership rather than through punishment and coercion... The sense of a community of scholars, an island of reason and tolerance, is the pervasive ethos. But that ethos should be advanced with education, not coercion. It should be the dominant voice of the university within the marketplace of ideas; but it should not preempt that marketplace. (Smolla 224-225).1 We emphatically concur. It is our position that a debater who feels strongly enough about a given language "argument" ought to actualize that belief through interpersonal conversation rather than through a plea for censorship and coercion. Each debater in a given round has three minutes of cross-examination time during which he or she may engage the other team in a dialogue about the ramifications of the language the opposition has just used. Additionally even given the efficacy of Rich Edwards' efficient tabulation program, there will inevitably be long periods between rounds during which further dialogue can take place.

There is no inherent link between speech acts and possible negative effects – language is fluid

Butler 97 (Judith, “Excitable Speech” UC-Berkeley, p. 15)

Those who seek to fix with certainty the link between certain speech acts and their injurious effects will surely lament the open temporality of the speech act. That no speech act has to perform injury as its effect means that no simple elaboration of speech acts will provide a standard by which the injuries of speech might be effectively adjudicated. Such a loosening of the link between act and injury, however, opens up the possibility for a counter-speech, a kind of talking back, that would be foreclosed by the tightening of that link. Thus, the gap that separates the speech act from its future effects has its auspicious implications: it begins a theory of linguistic agency that provides an alternative to the relenetless search for legal remedy. Te interval between instances of utterance not only makes the repetition and resignifcation of the utterance possible, but shows how words might, through time, become disjoined from their power to injure and recontextualized in more affirmative modes. I hope to make clear that by affirmative, I mean “opening up the possibility of agency” where agency is not the restoration of a sovereign autonomy in speech, a replication of conventional notions of mastery.

Cap K – Root Cause

Capitalism is the root cause of discrimination against disabled persons and the medical model

Lang 01 (Dr. Raymond Lang is a Senior Research Associate at the Overseas Development Group of the University of East Anglia, January, 2001, “The Development And Critique Of The Social Model Of Disability” www.ucl.ac.uk/lc-ccr/lccstaff/raymond-lang/DEVELOPMMENT\_AND\_CRITIQUE\_OF\_THE\_SOCIAL\_MODEL\_OF\_D.pdf)

Different ideological premises have profound implications for the explanation of disability. Oliver argued that in some societies, the presence of an impairment may not be perceived by society in pejorative terms, as it has been seen as a sign of being chosen. Hence, Safilios-Rothschild has stated:- “Throughout history, discriminatory practices against the sick and disabled have varied greatly from country to country and from century to century; they have ranged from complete rejection and ostracism to semideification and the according of special privileges and humours.” (Safilios-Rothschild, C. 1970:4) Oliver maintained that the economic structure and ideological hegemony of modern western society have had a major detrimental impact upon the lives of disabled people, and also other marginalised groups such as those with differing ethnic affiliations, or those with homosexual orientations. The rise of the factory system and the introduction of individual wage labour transformed the “means of production”, resulting in the separation of the home from the workplace, and in the marginalisation of disabled people, because they were unable to meet the demands of capitalist society. Disabled people have become further isolated from their family communities through the establishment of closed and segregated institutions, (which first came into existence in the late 19th century), whose function was to act as a mechanism for social control. In the latter half of the 20th century, closed and socially isolating institutions still exist which “warehouse” disabled people - for example, within many so called “special schools” and sheltered training workshops. However, during the past 20 years, throughout western-democratic societies, there has been a shift in government policy towards ensuring that disabled people live in community settings, where the package of “care” is bespoked to the individual needs. Within the UK context, this is referred to as the “care in the community programme”, (Priestley, 1999). Oliver further argued that in the wake of capitalism, dominant ideological presuppositions and modes of thought became commonly accepted, which again had detrimental consequences for the lives of disabled people. Analogous to Gramsci’s distinction between “organic” and “arbitrary” ideologies, He distinguished between “core” and “peripheral” ideologies, the latter being derived from the former. In relation to ideology, it was argued that the rise of capitalism necessitated the separation of work from home (as stated above), which in turn gave rise to the ideological construction of individualism, which became the “core” ideology vis-a-vis disability. Consequently, the rise of capitalism gave rise to the premise that disability is in essence an individual pathology, since a distinction needed to be drawn between those considered “ablebodied”, (and by implication able to work), and those who were considered disabled. Hence, within the modern capitalist era, “disabled people could not meet the demands of individual wage labour and so became controlled through exclusion”. This process of individualism gave rise to the peripheral ideologies of categorization and medicalisation of disability. In order to make a valid distinction between the deserving and undeserving poor, the agencies of the state assigned the medical profession the role of deciding who was disabled and who was not. This process, initiated during the 19th century, continues to have important ramifications for contemporary service provision, where it is commonly assumed that the greatest problems encountered by disabled people are directly related to their medical conditions. The medical profession still has a great deal of influence in the manner in which disabled people live, invariably being seconded by agencies of the state to make assessment of their needs and abilities, often in areas which have little to do with the application of medical science. Examples falling into this category would include the entitlement for financial grants, wheelchairs and other appliances, assessing the ability of a person to drive, and selecting appropriate educational provision. A possible explanation of the continued, and some would argue expanding, influence of the medical profession in the lives of disabled people is that the profession has widened its remit within the field of medical science to incorporate rehabilitation. Oliver, in support of this thesis, quoted Albrecht and Levy:- “As demand for rehabilitation services increased and insurance benefits expanded, there was an incentive for physicians to enter the rehabilitation field. Under the aegis of designing comprehensive medical rehabilitation programs, hospitals, and physicians began to incorporate rehabilitation services into the medical model. Definitions of disabling conditions and appropriate treatment were expanded to include medical interventions and physical control”. (Albrecht, G. and Levy J. 1981:22).

Cap K – Alt Solvency

Only rejecting capitalism solves

Shakespeare and Watson 02 (not THE Shakespeare, Tom Shakespeare is a Principal Research Associate in the School of Geography, Politics and Sociology at the University of Newcastle, has a PhD, is a knighted sociologist, and has achondroplasia, Nicholas Watson worked in the Department of Nursing Studies at University of Edinburgh and is now a professor at the University of Glasgow where he is the Chair of Disability Studies, 2002, “The social model of disability: an outdated ideology?” Research in Social Science and Disability, Volume 2, www.leeds.ac.uk/disability-studies/archiveuk/Shakespeare/social%20model%20of%20disability.pdf)

Again, Paul Abberley (1996) has been one of the pioneers in pointing out this limitation. He suggests that a barrier-free utopia, in which all disabled people can gain employment, is not viable. He points out that however much investment and commitment and energy is devoted to making work accessible, there will always be a residuum of people who, because of their impairment, cannot work. However, again we would disagree with his solution to the problem. While displacing work as the central social value would be undoubtedly an important social development, it is not the most obvious solution to a problem which is generated mainly by the limitations of social model reasoning. We see no reason why we cannot accept that not everyone will be able to achieve inclusion into the economy, and argue instead that a mature society supports everyone on the basis, not of the work they have done, but of the needs they have.

### Current federal law rejects the medical model

 Current federal law supports full inclusion in society – this is consistent with the social model, not the medical model

Winter 03 Jerry Alan Winter, Allyn Professor Emeritus of Sociology, Connecticut College Winter 2003, Volume 23, No. 1

Disability Studies Quarterly http://dsq-sds.org/article/view/399/545

This paper provides a sociological overview, based on the work of Fuller & Myers (1941), Blumer (1971), Mauss (1975), and Spector & Kitsuse (1977), of the development of a particular social movement, the disability rights movement in the United States. Of course, the United States is but one of the many countries in which such a movement has arisen (See: Charlton 1998; Newell 1999; Cooper 1999; Jayasooria 1999; Hayashi and Masako, 2001; and Gottlieb, 2001). As with many social movements, the disability rights movement arose to offer solutions to a social problem, viz., the oppressive marginalization of persons with disabilities. Its solution is basically, albeit not entirely, twofold. First, to empower persons with disabilities to take control of their own lives; and, second, to influence social policies and practices so as to further "the integration and full inclusion of individuals with disabilities into the mainstream of American society," as is now put in federal law (amended Rehabilitation Act of 1973, Title VII, Chapter 1, Section 701).

#### Existing federal law rejects the medical model

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With the articulation of the social model and the passage of the Rehabilitation Act of 1973 as amended in 1978, IDEA (1975) and ADA (1990), the ideological and legislative components of the disability rights movement's threefold program to solve problems facing people with disabilities were in place. The third component, the organizational, remained. It calls for the creation of independent living centers in which those with so- called disabilities would both be empowered to make their own efforts to enter society's mainstream and to be responsible for the success (or failure) of their efforts.

#### Federal transportation policy rejects the medical model

Devylder 11 Richard Devylder, Department of Transportation 9-12-11 U.S. Launch and Symposium for the World Report On Disability http://cirrie.buffalo.edu/conferences/2011/report.pdf

• The United States shares the recognition of the need for enabling environments in the area of transportation. Two major pieces of legislation-initiated action programs by the U.S. government have improved access to transportation: the Americans with Disabilities Act (now celebrating its twenty-first anniversary) and the Air Carrier Access Act (now in its twenty-fifth year).

• The U.S. government and its advisors have recognized that innovating change in environments needs a different perspective. PWDs [persons with disabilities] can no longer be seen as a part of the “medical model”, but as consumers in search of equality and rights.

• The U.S. programs for transportation accessibility are broad ranging and focus on what the individual may do in public transportation. Everything that a non-disabled person can do (e.g., board a bus, train, or car; access any sidewalk; access an airplane; go on a cruise ship) must be available to citizens with disabilities.

• A diverse program of improvement to transportation systems in the United States is governed by federal rules and monitored by the Department of Transportation, particularly the Federal Transit Administration, the Aviation Consumer Protection Division of the Department of Transportation Enforcement Office, the Federal Railroad Administration, the Federal Highway Administration, and the Federal Motor Carrier Safety Administration. Guidelines for standards of accessibility in public rights-of- way are provided by the U.S. Access Board, in cooperation with the monitoring agencies.

Federal law has moved away from the medical model

Schmeling et al 03 James Schmeling, Helen Schartz, and Peter Blanck 2003 The New Disability Law and Policy Framework: Implications for Case Managers <http://bbi.syr.edu/publications/blanck_docs/2003-2004/ch4DisabilityLaw051704FINAL.pdf>

The medical model of disability focused on the individual, whose condition was seen as an infirmity that precluded participation in society. The medical model never considered the effects of the physical and social environment in which people with disabilities were forced to function. Instead, it countenanced the segregation and economic marginalization of individuals with disabilities (Drimmer, 1993; Hahn, 2000; Milani, 1999). Because the medical model aimed to address the needs of people with disabilities rather than recognize their rights, it led to government policies that viewed assistance for people with disabilities as a form of either charity or welfare.

Disability laws and policies have undergone a dramatic shift from a model of charity and compensation, to medical oversight, and then to civil rights (Blanck, 2000; Blanck & Millender, 2000). Contemporary employment policies and laws are focused on increasing the labor force participation of qualified persons with disabilities and reducing their dependence on government entitlement programs. Federal laws, such as the Workforce Investment Act of 1998 (WIA), the Rehabilitation Act of 1973 as reauthorized in WIA, the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), and the Americans with Disabilities Act of 1990 (ADA), illustrate public support for enhancing employment opportunities for working age adults with disabilities and preventing discrimination in the workplace (Blanck, 2000; Blanck et al., 2003).

### ADA is consistent with rejecting the medical model

#### The disability rights movement considers the ADA as part of the solution to the medical model

Winter 03 Jerry Alan Winter, Allyn Professor Emeritus of Sociology, Connecticut College Winter 2003, Volume 23, No. 1

Disability Studies Quarterly http://dsq-sds.org/article/view/399/545

 In all, the disability rights movement proposed solution to the problem of the oppressive marginalization of people with disabilities entails a three pronged approach: 1) the ideological, challenging the medical model and proposing to replace it with a new one, the social model, as the proper model for understanding disability; [and] 2) the legislative, proposing new laws, e.g., the Americans with Disabilities Act (ADA), to guarantee the rights of those with impairments; and 3) the organizational, proposing the creation of Independent Living Centers in which those with impairments are be responsible for their own success (or failure).

The Social Model

The old, medical model, as noted above, is a plausibility structure, i.e., a set of policies and procedures, whose premises unobtrusively control the lives of people with impairments. Indeed, it is a structure which oppresses such persons by rendering them disabled and dehumanized. Specifically, according to the medical model, the problems facing persons with a disabilities are, simply, medical problems. Medical problems, of course, call for treatment by an array of medical professionals. Submission to professional treatment, as viewed by the medical model, renders the impaired (sick) person passive, unable to exhibit the defining mark of personhood, the control of one's own affairs. Consequently, the disability rights movement views the medical model as oppressive, a major source of the exclusion of people with impairments disabilities from the mainstream, the putative domain of "healthy," unimpaired people.

#### The ADA was a result of rejection of the medical model

Blanck 04 Peter Blanck, Professor of Law, Professor of Public Health and of Psychology, University of Iowa, and Director of the Law, Health Policy, and Disability Center (LHPDC) at the University of Iowa College of Law 2004 The Journal of Gender, Race & Justice Keynote Address Justice for All? Stories about Americans with Disabilities and Their Civil Rights

bbi.syr.edu/publications/blanck\_docs/2003.../8\_JGRJ\_2004.doc

In prior studies, my colleagues and I attached significance to the fact that in the 1970s and 1980s, national policies directed at the civil rights of people with disabilities rapidly replaced a medical conception of disability, which structured policy for most of the twentieth century. This medical model had roots in the Civil War Pension program under which disabled Union Army veterans were awarded monetary pensions based on their incapacity to perform manual labor. The medical model saw disability as an infirmity that precluded equal participation in society. It posited that government provide resources to cure the worthy disabled of their impairments.

The medical model that continued to evolve after the First World War (with passage of the national Vocational Rehabilitation Act ) and well into the 1960s (with Medicaid entitlement programs for the poor and disabled) placed people with disabilities in subordinate roles with government, physicians and rehabilitation professionals, who sought to help the disabled adjust to a society structured around the convenience and interests of the nondisabled. Because the medical model did not consider the physical and social environment as disabling, it countenanced segregation and economic marginalization. And because it focused on needs of the disabled, it did not recognize their civil rights. This legacy contributed to policies that structured assistance for the disabled as welfare and charity, with public attitudes in accord.

Until passage of the ADA, contemporary employment, health care, and rehabilitation programs for persons with disabilities were modeled on such medicalized stereotypes about disability. The rights model that began to influence policy in the 1970s conceptualized people with disabilities as a minority group, entitled to the protections that emerged from the struggles of women and African-Americans for equality. During this time, people with disabilities, both as individuals and in organized groups, asserted their rights to challenge stereotypes about dependency in education, housing, health care, transportation and employment.[[1]](#footnote-1)

In the 1970s, national disability policy also began to integrate concepts of the independent living philosophy. Prominently, Title VII of the Rehabilitation Act of 1973[[2]](#footnote-2) initiated funding for Centers for Independent Living (CILs). Not only did the CILs provide services *for* individuals with disabilities, but also they were to be operated *by* individuals with disabilities.[[3]](#footnote-3) CILs have grown from ten centers in 1979 to over three hundred and fifty.[[4]](#footnote-4)

The new disability policy framework,[[5]](#footnote-5) grounded in equal rights, inclusion, empowerment and economic independence, fostered passage of federal and state laws from accessibility in voting and air travel, to independence in education and housing, and culminating with passage of the ADA.

The ADA supports the social model with full inclusion

Winter 03 Jerry Alan Winter, Allyn Professor Emeritus of Sociology, Connecticut College Winter 2003, Volume 23, No. 1

Disability Studies Quarterly http://dsq-sds.org/article/view/399/545

It did so, first, by, in effect, making the marginalization, the exclusion of people with impairments from the mainstream of society in the United States, illegitimate. Specifically, it declared that "people with disabilities are an integral part of society and, as such, should not be segregated, isolated, or subjected to the effects of discrimination" (National Council on Disability 1997b: 4). Furthermore, it sought to enable "people with disabilities to take charge of their lives . . . by fostering employment opportunities, facilitating access to public transportation and public accommodation, and ensuring the use of our nation's communication system" (National Council on Disability 1997b: 4). Moreover, the principles of the ADA can serve as a basis to test and challenge public policies and practices not consistent with those principles and even to demand they be changed. The ADA, then, "upholds the principle that each individual has the potential, and deserves, the right to participate in, and contribute to, society" (National Council on Disability 1997b: 5).

In the words of President Bush, at the signing ceremony, "The Act . . . will ensure that people with disabilities are given the basic guarantees [of] . . . [i]ndependence, control of their lives, [and] the opportunity to blend fully and equally into the . . . mosaic of the American mainstream" (National Council on Disability 1997b: 58). In short, ADA enacts the slogan of the disability rights movement, "nothing about us, without us," into law and renders the oppressive marginalization of people with impairments illegal and, perhaps, even un-American or, at least, unacceptable to the mainstream of American society.

### States are required to act under ADA Title II

#### States are required to provide access under Title II of the ADA

Southwest ADA Center 2012 ADA Title II: State and Local Government Programs and Services

http://ilru.org/dlrp/html/guide\_to/titleII.html

Title II requires that State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services, and activities (e.g. public education, employment, transportation, recreation, health care, social services, courts, voting, and town meetings).

DOJ 09 U.S. Department of Justice - Published: 2009-01-04 Disabled World ADA Title II: State and Local Government

http://www.disabled-world.com/disability/ada/government-activities.php

ADA Title II covers all activities of State and local governments regardless of the government entity's size or receipt of Federal funding.

Title II requires that State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services, and activities (e.g. public education, employment, transportation, recreation, health care, social services, courts, voting, and town meetings).

#### Title II is not tied to receiving federal funds

DOJ 02 U.S. Department of Justice, Civil Rights Division, Disability Rights Section 8-29-02

Title II Highlights http://www.ada.gov/t2hlt95.htm

Who is Covered by Title II of the ADA

 The title II regulation covers "public entities."

 "Public entities" include any State or local government and any of its departments, agencies, or other instrumentalities.

 All activities, services, and programs of public entities are covered, including activities of State legislatures and courts, town meetings, police and fire departments, motor vehicle licensing, and employment.

 Unlike section 504 of the Rehabilitation Act of 1973, which only covers programs receiving Federal financial assistance, title II extends to all the activities of State and local governments whether or not they receive Federal funds.

### ADA indicts don't apply

#### Indicts of the ADA don't apply (to the counterplan)

Under the counterplan, state governments interpret the ADA as requiring Universal Access, but the counterplan doesn't apply or use the ADA itself. Problems with the ADA don't apply because all the counterplan does is Universal Access

#### ADA problems apply to the plan just as much

The aff doesn't do anything about the problems with the ADA. They would exist just as much with the plan.

### Federal laws

There are a number of federal laws in the area supported by the disability rights movement

Winter 03 Jerry Alan Winter, Allyn Professor Emeritus of Sociology, Connecticut College Winter 2003, Volume 23, No. 1

Disability Studies Quarterly http://dsq-sds.org/article/view/399/545

In 1968, the Architectural Barriers Act was passed. It stipulated that any facility built with or merely receiving federal funds had to be accessible to all. However, enforcement was minimal (Varela 1983: 36). Fortunately, the Rehabilitation Act of 1973, in a provision welcomed by the disability right movement, established the Architectural and Transportation Barriers Compliance Board (A&TBCB) to investigate and enforce compliance with established standards. Unfortunately, it "never received the funding it needed to enforce the law or even to investigate all . . . violations . . . reported by disabled consumers" (Varela 1983: 37). Nevertheless, the fight for accessibility did advance the cause of the disability rights movement. It helped make it clear that barriers included "social, political and in

Moreover, the 1973 Rehabilitation Act contained provisions in addition to the establishment of the A&TBCB which were important to the movement (Varela 1983: 40-41). It required the establishment, by state rehabilitation agencies, of selection methods that would ensure that people with severe impairments were not excluded from the agency's programs. In effect, then, the Act made it clear that no impairment, no matter how severe, was to be allowed as a consequences of a state agency's denial of services to become a disability. In addition, the 1973 act included provisions for client rights and for civil rights.

Specifically, Section 504 prohibited discrimination against persons with so-called disabilities by any federally supported program. Thus, Section 504 was important to persons with so- called disabilities "who were looking for jobs . . . who wanted to use the same clinic as everyone else, who wanted the same choice of apartments, and who wanted to get into the polling places on election day" (Varela 1983: 42), who wanted simply to be an autonomous, contributing member of society.

The next step in the history of legislation to empower and include people with impairments was the passage of Individuals with Disabilities Education Act (IDEA, originally called the Education for All Handicapped Children Act of 1975, P. L. 94-142). IDEA set "forth a comprehensive scheme" to ensure "two basic substantive rights of eligible children with disabilities . . . ." These were: "(1) the right to a free appropriate public education, and (2) the right to that education in the least restrictive environment" (National Council on Disability 2000: 28). The law applied in every state that receives federal funds under IDEA and to all public agencies authorized to provide special education and related services in a state that receives such funds. The Act was amended and reauthorized in 1997 (NCD 2000 30-31).

In 1978, the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments (P. L. 95-602) of the 1973 Rehabilitation Act were passed. The amendments evinced Congress' endorsement of the autonomy premise of the social model described above. That is, the Amendments acknowledged that persons with disabilities should be involved in forming the policies and practices which affect their lives. Specifically, it mandated that a grant for an independent living center "provide assurances that handicapped individuals be substantially involved in [the] policy direction and management of such center, and will be employed by such center" (P. L.. 95-602 as quoted by Varela 1983: 46).

Many, if not most, however, view the enactment of the Americans with Disability Act (ADA) in 1990 as the crowning achievement of the disability rights movement. That act (P. L. 101-336) extended provisions of the Rehabilitation Act of 1973 and the 1978 amendments well beyond the earlier application to federally supported programs and the state rehabilitation agencies and of the IDEA to special education. Indeed, it "codified into law important principles that would henceforth govern the relationship between [American] society and its citizens with disabilities . . . [and] altered public discourse about disability and about the role of people with disabilities in American society" (National Council on Disability 1997b: 4-5).

### Medical Model and Social Model Defined

#### The medical models sees disability as a problem with the person. The social model sees the problem as created by society and its exclusionary practices – it acts to make social participation fully available

Disabled World News 2010-09-10 Disabled World Definitions of The Models of Disability <http://www.disabled-world.com/>definitions/disability-models.php

The Medical Model of Disability:

The medical model is presented as viewing disability as a problem of the person, directly caused by disease, trauma, or other health condition which therefore requires sustained medical care provided in the form of individual treatment by professionals. In the medical model, management of the disability is aimed at a "cure," or the individual’s adjustment and behavioral change that would lead to an "almost-cure" or effective cure. In the medical model, medical care is viewed as the main issue, and at the political level, the principal response is that of modifying or reforming healthcare policy.

The Social Model of Disability:

The social model of disability sees the issue of "disability" as a socially created problem and a matter of the full integration of individuals into society. In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence, the management of the problem requires social action and is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is both cultural and ideological, requiring individual, community, and large-scale social change. From this perspective, equal access for someone with an impairment/disability is a human rights issue of major concern.

**Security means the potential for emancipation, not mere survival. Safety is the only foundation for human flourishing**

Booth 05, Ken, Prof. of IR at Wales, Critical Security Studies and World Politics, p. 22

The best starting point for conceptualizing security lies in the real conditions of insecurity suffered by people and collectivities. Look around. What is immediately striking is that some degree of insecurity, as a life determining condition, is universal. To the extent an individual or group is insecure, to that extent their life choices and chances **are taken away**; this is because of the resources and energy they need to invest in seeking safety from domineering threats - whether these are the lack of food for one’s children or organizing to resist a foreign aggressor. The corollary of the relationship between insecurity and a determined life is that **a degree of security creates life possibilities**. Security might therefore be conceived as synonymous with **opening up space in people’s lives.** This allows for individual and collective **human becoming** - the capacity to have some choice about living differently - consistent with the same but different search by others. Two interrelated conclusions follow from this. First, security can be understood as an instrumental value; it frees its possessors to a greater or lesser extent from life-determining constraints and so allows different life possibilities to be explored. Second, security is synonymous simply with survival. One can survive without being secure (the experience of refugees in long-term camps in war-torn parts of the world, for example). Security is therefore more than mere animal survival (basic animal existence). It is survival-plus, the plus being the possibility to explore human becoming, As an instrumental value, security is sought because it frees people(s) to some degree to do other than deal with threats to their human being. The achievement of a level of security - and security is always relative - gives to individuals and groups some time, energy, and scope to chose to be or become, other than merely survival as human biological organisms. Security is an important dimension of the process by which the human species can reinvent itself beyond the merely biological.

**Human extinction is the greatest act of suffering imaginable – using scientific methods to forestall extinction is crucial**

**Epstein and Zhao 09** (Richard J. Epstein and Y. Zhao ‘9 – Laboratory of Computational Oncology, Department of Medicine, University of Hong Kong, The Threat That Dare Not Speak Its Name; Human Extinction, Perspectives in Biology and Medicine Volume 52, Number 1, Winter 2009, Muse)

Human extinction is 100% certain—the only uncertainties are when and how. Like the men and women of Shakespeare’s As You Like It, our species is but one of many players making entrances and exits on the evolutionary stage. That we generally deny that such exits for our own species are possible is to be expected, given the brutish selection pressures on our biology. Death, which is merely a biological description of evolutionary selection, is fundamental to life as we know it. Similarly, death occurring at the level of a species—extinction—is as basic to biology as is the death of individual organisms or cells. Hence, to regard extinction as catastrophic—which implies that it may somehow never occur, provided that we are all well behaved—is not only specious, but self-defeating.  Man is both blessed and cursed by the highest level of self-awareness of any life-form on Earth. This suggests that the process of human extinction is likely to be accompanied by more suffering than that associated with any previous species extinction event. Such suffering may only be eased by the getting of wisdom: the same kind of wisdom that could, if applied sufficiently early, postpone extinction. But the tragedy of our species is that evolution does not select for such foresight. Man’s dreams of being an immortal species in an eternal paradise are unachievable not because of original sin—the doomsday scenario for which we choose to blame our “free will,” thereby perpetuating our creationist illusion of being at the center of the universe—but rather, in reductionist terms, because paradise is incompatible with evolution. More scientific effort in propounding this central truth of our species’ mortality, rather than seeking spiritual comfort in escapist fantasies, could pay dividends in minimizing the eventual cumulative burden of human suffering.

**The 1NC is necessary discourse – combating complacency is crucial to halting certain and inevitable extinction**

**Epstein and Zhao 09** (Richard J. Epstein and Y. Zhao ‘9 – Laboratory of Computational Oncology, Department of Medicine, University of Hong Kong, The Threat That Dare Not Speak Its Name; Human Extinction, Perspectives in Biology and Medicine Volume 52, Number 1, Winter 2009, Muse)

We shall not speculate here as to the “how and when” of human extinction; rather, we ask why there remains so little discussion of this important topic. We hypothesise that a lethal mix of ignorance and denial is blinding humans from the realization that our own species could soon (a relative concept, admittedly) be as endangered as many other large mammals (Cardillo et al. 2004). For notwithstanding the “overgrown Petri dish” model of human decline now confronting us, the most sinister menace that we face may not be extrinsic selection pressures but complacency. Entrenched in our culture is a knee-jerk “boy who cried wolf ” skepticism aimed at any person who voices concerns about the future—a skepticism fed by a traditionally bullish, growth-addicted economy that eschews caution (Table 1). But the facts of extinction are less exciting and newsworthy than the roller-coaster booms and busts of stock markets.

**War will escalate and cause extinction — High alert guarantees**

**Phillips 2k** DR Alan Phillips Oct. 2000 http://www.peace.caInuclearwinterrevisitedhtm

With thousands ofrocket-launched weapons at launch-on-warning”, any day there could bean all-outnuclear warby accident. The fact that there are only half as many nuclear bombs as there were in the 80’s makes no significant difference. Deaths from world-wide starvation afterthe war would be several times the number from direct effects of the bombs, and the **surviving fraction** of the human race **might then diminish and** **vanish** after a few generations of hunger and disease, in a radioactive environment**.**

1. *.See* Joseph P. Shapiro, No Pity: People with Disabilities Forging a New Civil Rights Movement (1993) (reviewing the history of modern disability rights movement). [↑](#footnote-ref-1)
2. .29 U.S.C. §§ 796−796f (2000). [↑](#footnote-ref-2)
3. *.See generally* Heather Ritchie & Peter Blanck, *The Promise of the Internet for Disability: A Study of On-line Services and Web Site Accessibility at Centers for Independent Living*, 21 Behav. Sci. & L. 5 (2003). [↑](#footnote-ref-3)
4. .In 2002, there were 368 CILs, with approximately 207 satellite offices. *Id*. at 7 (citation omitted). [↑](#footnote-ref-4)
5. *.See generally* Robert Silverstein, *Emerging Disability Policy Framework: A Guidepost for Analyzing Public Policy*,85 Iowa L. Rev. 1691 (2000) (describing the new disability policy framework). [↑](#footnote-ref-5)