The WHO call for urgent action to advance health equity, set in the context of the UN Convention on the Rights of Persons with Disabilities and the UK Equality Act

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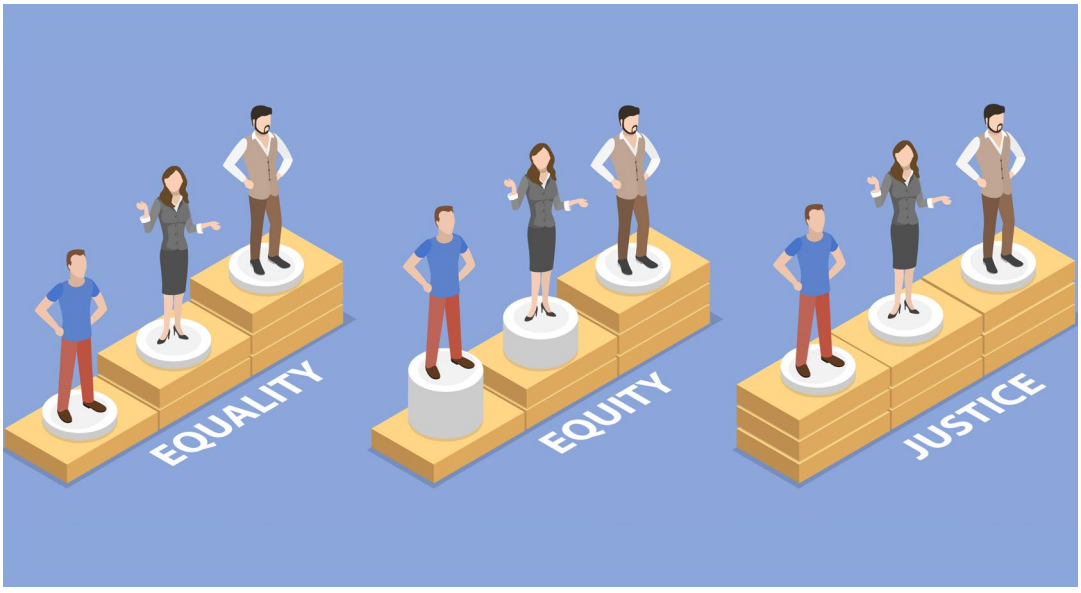

The World Health Organization's (WHO) call for urgent action to reduce health inequities for persons with disability is set in the context of the Convention on the Rights of Persons with Disabilities, the UK Equality Act, professional obligations and reports of discrimination in clinical psychology practice. Suggestions for immediate professional action are outlined.
Keywords: *Disability rights; Equality Act; Discrimination; Health inequities; Clinical psychology.*

Introduction

WHO (2022) call for urgent action to advance health equity for persons with disabilities. Whilst noting substantial progress since 2011, it is concluded that we remain far from realising the right to the highest attainable standard of health for persons with disabilities (WHO, 2022). Governments and health sector partners are called upon to strengthen health systems to reduce inequities. This parallels the call in *'Being disabled in Britain: A journey less equal'* from the UK Equality and Human Rights Commission (EHRC, 2017):

> *'It is a badge of shame on our society that millions of disabled people in Britain are still*

> *not being treated as equal citizens and continue to be denied the everyday rights non-disabled people take for granted, such as being able to access transport, appropriate health services and housing, or benefit from education and employment. The disability pay gap is persistent and widening, access to justice has deteriorated, and welfare reforms have significantly affected the already low living standards of disabled people. It is essential that as a society we recognise and address these structural problems urgently and comprehensively. We are calling for a new national focus on disability rights, so that disabled people are no longer treated as "second class citizens".'*

Disability rights are set out in the UN Convention on the Rights of Persons with Disabilities (UNCRPD, 2006). This aims '*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'* (Article 1). *'Discrimination on the basis of disability is any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation'* (Article 2).

The UK was the first country to be investigated for alleged violations of the UNCRPD. This was prompted by reports from 2012 onwards of the disproportionate adverse impact of benefits cuts, with people with disability nearly three times as likely to experience severe material deprivation as people without disability (EHRC, 2019). The UN Inquiry concluded that *'there was reliable evidence that the threshold of grave or systematic violations of the rights of persons with disabilities had been crossed'* (CRPD, 2017a). This reflects personal experience of a '*war on disabled people'* (Clifford, 2020).

In the UK, UNCRPD requirements are incorporated in the Equality Act (EqA) (2010). However, combining equality legislation has not worked well for people with disability (e.g. widespread difficulty in securing reasonable adjustments) (Select Committee, 2016). The Women and Equalities Committee (2019) also highlight lack of enforcement of the EqA. Reports of disability discrimination in training, recruitment, practice and management suggests that clinical psychologists lack understanding of the UNCRPD and EqA. Whilst noting that psychology has a rich tradition of diversity and individual difference, disability has largely been left out of this and psychology *'must play a stronger role in advancing the human rights of people with disabilities*' (Andrews et al. 2019).

My experience of human rights is specific to disability as a concerned practitioner and also family member with no legal expertise. I draw extensively on EHRC guidance but recognise the risk of citing extracts out of context. As such, reading the full guidance is recommended. Whilst many UNCRPD and EqA requirements and the WHO recommendations are dependent on Government and/or organisational level action, some professional actions are suggested for consideration. These include completing a disability discrimination awareness questionnaire and practice checklist and recommended reading. However, first some key disability facts.

UK Disability facts (source: Kirk-Wade, 2022)

An estimated 14.6 million people (22 per cent of UK population) have a disability. Prevalence rises with age: 9 per cent of children, 21 per cent of working-age adults, 42 per cent of adults over state pension age, 59 per cent aged over 80. The proportion with disability has risen 3 percentage points in 10 years.

In terms of educational qualifications, 24.9 per cent of people with a disability aged 21 to 64 attained a degree compared with 42.7 per cent of people without a disability; 13.3 per cent of people with disability have no qualifications, compared with just 4.6 per cent of people without disability.

An estimated 7.5 million people of working age report disability, of whom 53.8 per cent are in work, compared with 82.0 per cent in work for those without disability, a disability employment gap of 28.2 percentage points. In 2018, the UK gap was larger than 21 of 31 EU countries.

An estimated 14.3 per cent of people with disability report domestic abuse compared with 5.1 per cent without disability. Adults with disability are twice as likely to report sexual assault (3.7 per cent vs. 1.9 per cent), children with disability nearly twice as likely to be a victim of crime (12.0 per cent vs 6.3 per cent).

People with disability report lower wellbeing with, for example 15.1 per cent feeling lonely often or always compared with 3.6 per cent of people without disability.

Global report on health equity for persons with disabilities (WHO, 2022)

Worldwide, an estimated 1.3 billion people have a disability (WHO, 2022), 'the world's largest minority'. Numbers are growing because of an increase in non-communicable diseases and people living longer. People with disability may die earlier and have twice the risk of conditions such as depression, asthma, diabetes, stroke, obesity, poor oral health. They find inaccessible health facilities are up to 6 times more difficult, transportation 15 times more difficult. Evidence is that these 'health inequities' arise from unfair conditions:

- ***Structural factors***: Ableism, stigma, discrimination, restrictive laws and policies.
- ***Social determinants*:** Poverty, exclusion from education and employment, poor living conditions and gaps in support.
- ***Risk factors:*** Higher prevalence of risk factors for non-communicable disease.
- ***Health system:*** Barriers in all aspects of the health system (e.g. knowledge, negative attitudes, discrimination, inaccessible facilities/information, lack of data on disability).

WHO recommend 40 actions across 10 domains. The workforce recommendations focus on competencies for disability inclusion in education of all health/care workers, training in disability inclusion for all health providers and a skilled health and care workforce which includes persons with disabilities. These will be set in the context of the UNCRPD and EqA.

The UN Convention on the Rights of Persons with Disabilities

The UNCRPD (2006) represents a paradigm shift to a social model of disability (Series, 2020). This requires equal access to transport, communications, justice, independent living, mobility, education, health, work and employment, and also equal participation in political and public life, culture, recreation, leisure and sport. Article 4 outlines the wide range of actions necessary to achieve realisation of all human rights and fundamental freedoms. Article 5 requires legal protection against discrimination, promotion of equality and all appropriate steps to ensure reasonable accommodation. Article 8 requires measures: to raise awareness and foster respect for human rights and dignity; to combat stereotypes, prejudices and harmful practices; and to promote awareness of capabilities and contributions. Articles 24–27 are particularly relevant to health equity:

Education (24): An inclusive system at all levels directed to: full development of potential, dignity and self-worth and strengthening of respect for human rights, fundamental freedoms and diversity; development of personality, talents and creativity, as well as mental/physical abilities, to their fullest potential; and participation in society.

Health (25): Persons with disabilities are to be able to enjoy the highest attainable standard of health without discrimination. This requires disability-related rehabilitation and health professionals to provide care of equal quality (e.g. by raising awareness of human rights, dignity, autonomy and needs of persons with disabilities through training and standards). (Article 16 also requires all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities

who become victims of any form of exploitation, violence or abuse.)

Habilitation/rehabilitation (26): Effective measures are required to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. This requires training for professionals and other staff including on assistive devices and technologies.

Work/employment (27): Persons with disabilities have a right to work, on an equal basis in an environment that is open, inclusive and accessible. This includes prohibiting discrimination in all matters of employment and ensuring that reasonable accommodation is provided.

All state signatories are obliged to promote the training of professionals working with persons with disabilities on the UNCRPD. However, I am not aware of any such training.

UK 'violations' of the UNCRPD

The identified UK violations of the UNCRPD included: freedom of choice and control over daily activities had been restricted; the extra cost of disability had been set aside and income protection curtailed as a result of benefit cuts; reasonable accommodation had been denied in assessment procedures and in the realisation of the right to employment (CRPD, 2017a). Initial recommendations called for a cumulative impact assessment and a rights-based approach to disability, along with action on budgets, accessible information, access to justice, discriminatory stereotypes/prejudice, low income or poverty and risk of exclusion. The UK Government disputed these findings. The Committee's concluding observations raised, on my count, 65 concerns and 85 recommendations (CRPD, 2017b).

A year later, whilst some progress was reported, the four UK Equality Commissions noted *'continued reluctance'* to accept the Inquiry conclusions, lack of a comprehensive strategy and only limited steps to action the recommendations (UK Independent Mechanism, 2018):

> *'Disabled people across the UK continue to face serious regression of many of their rights, as presented in this report. Social protections have been reduced and disabled people and their families continue to be some of the hardest hit. More and more disabled people are finding it difficult to live independently and be included, and participate, in their communities on an equal basis.'*

Whilst many actions lie outside our control, clinical psychologists can promote inclusive education and employment and tackle barriers in access to health services for those with psychological difficulties. The experience of providing vocational rehabilitation for people with brain injury is that we can play a key role both in identifying needs and in advocating for, advising on and supporting provision of reasonable adjustments in both further/higher education and in employment. We can also advise others on tailoring healthcare to accommodate complex psychological needs. This is likely the case for many other client groups we work with. We also need to play our part in addressing the high suicide rate noted in people with disabilities. The UNCRPD requirements are covered in the Equality Act 2010.

The UK Equality Act 2010 (sources: EHRC statutory codes and technical guidance)

The Equality Act 2010 (EqA) protects anyone who has, or has had, one of nine 'protected characteristics' (including disability) against discrimination in a wide range of situations including education, employment and as a service user. Disability is defined as *'physical or mental impairment which has a long-term and substantial adverse effect on ability to carry out normal day-to-day activities'*. Disability discrimination includes the following:

Direct discrimination is treating a person less favourably because of a disability or based on a stereotype relating to a disability. This is unlawful regardless of motive, intent, whether done consciously or unconsciously or whether aware of treating the person differently.

Indirect discrimination occurs when an apparently neutral provision, criterion or practice (e.g. 'policies, rules, practices, arrangements, criteria, conditions, prerequisites, provisions or qualifications) puts persons with disability at a disadvantage. Reasonable adjustments are commonly required to reduce this disadvantage.

Discrimination arising from disability occurs when a person is treated unfavourably because of something arising in consequence of disability (e.g. disability-related absence), unless the treatment can be shown to be a 'proportionate means of achieving a legitimate aim'. Again, reasonable adjustments are commonly required.

Failure to make reasonable adjustments ('accommodation' in UNCRPD): The duty to make reasonable adjustments requires positive steps to enable people with disability to access education, services or work on as equal a basis as possible. Unless doing so would impose 'a disproportionate or undue burden', failure to provide a reasonable adjustment will often constitute a denial of human rights under the UNCRPD and be unlawful under the EqA.

Harassment occurs when unwanted conduct has the purpose or effect of violating the dignity of a person or of making them feel humiliated, offended or degraded. This includes spoken or written words or abuse, imagery, graffiti, physical gestures, facial expressions, mimicry, jokes, pranks, acts affecting a person's surroundings or other physical behaviour.

Victimisation occurs when a person is subjected to a 'detriment' because a complaint of discrimination or any 'protected act' related to implementation of the EqA. It is also unlawful to instruct someone or to help, cause or induce (or attempt to help, cause or induce) a person to discriminate against or harass or victimise a third person.

The ***Public Sector Equality Duty (PSED)*** requires public bodies to pay due regard to the needs of all individuals: to eliminate unlawful discrimination, harassment, victimisation and other unlawful conduct; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not.

The EqA is comprehensive, yet I recall no detailed training. The mandatory NHS training on equality, diversity and inclusion covers all nine EqA protected characteristics and cannot possibly do justice to disability needs. (The EHRC statutory guidance on employment alone is 81,000 words, the guidance on services 60,000 words).

The Equality Act in practice

The Select Committee (2016) on the Equality Act and Disability outlined concerns about the merging of equality legislation. Whilst equality of opportunity for people with other protected characteristics is largely achieved by equality of treatment, different treatment is required for persons with a disability. The name itself implies equality of treatment, which is '*insufficient to afford real equality for people with disability and may even militate against it'*. As illustrated in the article image, equal treatment just maintains the existing disadvantage of disability. Whilst equity involves differential compensatory adjustment, 'justice' would be achieved through 'universal design', that is '*the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design'* (UNCRPD, 2006, Article 2).

Reasonable adjustment is a 'cornerstone' of the EqA (EHRC, 2011a), yet evidence is noted of problems in obtaining reasonable adjustments '*emanating from almost every part of society' (Select Committee, 2016).* This includes employers, education, on buses and trains, in taxis, shops, restaurants, hospitals. sports grounds, entertainment venues, in the justice systems and in bodies supporting people with disability. Many employers still do not understand the need to treat persons with disability favourably to achieve

equality in practice by making adjustments, which is still often seen as showing '*favouritism'*. The need for a code of practice on reasonable adjustments and specific industry-based guidance were identified to prevent unlawful acts *'because of ignorance'* of obligations. (Select Committee, 2016).

The Women and Equalities Committee (2019) highlight the destructive personal and societal cost of discrimination. EqA enforcement relies on individual legal action and is noted not to be fit for purpose. Few people can pursue such action as a result of legal complexity, lack of specialist support, the high cost of action, limited access to legal aid, the stress of claims and often low level of compensation awarded. It was noted that regulatory bodies in employment, education, health, housing, transport and service provision are bound by the EqA and PSED but lack knowledge of their duties, with enforcement '*patchy at best*'.

As such, the EqA is commonly *'breached without challenge and … what little enforcement is happening is insufficient to tackle the systemic or routine discrimination that too many people experience as a simple fact of life'*. A shift to a deterrent model is advocated, making obligations on employers, public bodies and providers more explicit and enforceable. EHRC needs to work with enforcement bodies including regulators, inspectorates and ombudsmen. Such bodies are far better placed '*to combat the kind of routine, systemic, discrimination matters where the legal requirements are clear and employers, service providers and public authorities are simply ignoring them because there is no realistic expectation of sanction'* (Women and Equalities Committee, 2019).

Professional duties and concerns

The NHS Constitution (UK Government, 2021) stresses respect for human rights and a wider social duty to promote equality, particularly where health and life expectancy lag behind the rest of the population. Service users and staff have a right not to be discriminated against. Staff also have a duty not to discriminate against both patients and staff, to adhere to equal opportunities and human rights legislation, to contribute towards 'fair and equitable services for all' and wherever possible, to help 'to reduce inequalities in experience, access or outcomes'.

BPS Practice Guidelines (BPS, 2017) state that equality of opportunity should be *'embedded in all thinking and all practice'*. The Health and Care Professions Council (HCPC, 2016) states that registered practitioners: '*must not discriminate against service users, carers or colleagues'* and '*must challenge colleagues if you think that they have discriminated against, or are discriminating against, service users, carers and colleagues'*. From September 2023 revised HCPC Standards of Proficiency will also include a requirement to *'understand the duty to make reasonable adjustments in practice and be able to make and support reasonable adjustments in theirs and others' practice'*.

Yet, at the last count, I am aware of 280 concerns of disability discrimination and related action related to clinical psychology. (This excludes concerns about any discriminatory course selection criteria.) To put these concerns in context, the experience of running a high profile example of good practice in vocational rehabilitation after brain injury has attracted many external reports of discrimination from and via national colleagues, family and friends, as well as those relating to our local service clients and staff.

Overall, 185 reported concerns relate to clinical psychology training, 73 to the NHS, 18 to other employers and four to other courses. Of 39 NHS user concerns, almost all relate to remote working in the pandemic or employers relating to our clients. Of 23 NHS staff concerns all bar one involve reasonable adjustments. Whilst the NHS concerns involve many parties, the training reports affect a much smaller number of trainees, who are not free to seek an alternative position as others are. Overall, the concerns include 209 specific actions by at least 20 clinical psychologists across 5 universities and 12 services, all of which relate to trainees, job applicants or staff, but not to service users.

Whilst there is a need to refine classification (e.g. categories overlap), on provisional review, the 228 discrimination concerns breakdown as follows: reasonable adjustments 119, harassment

31, indirect discrimination 25, discrimination arising from disability 25, direct discrimination 14, and victimisation 14. The 52 other concerns include failure to follow policy/process; inaccurate or misleading information to investigators, regulators or to legal proceedings; failure to declare conflicts of interest; and a lack of response to findings.

In spite of complaints, the reported discrimination was noted often to continue unresolved and, in a few cases, was compounded by harassment and/or victimisation. Many concerns were raised internally, externally and with regulatory bodies. In my view, based on the details provided, a high proportion of concerns warrant taking legal advice. To date, I am aware of 9 related legal claims (5 against NHS Trusts, 4 against universities).

Discussion

The above reports reinforce concerns about disability discrimination in clinical psychology. Whilst my specific experience has likely attracted a disproportionate number of reports, two-thirds of participating psychologists with disability reported experiencing discrimination in the USA, with only around half disclosing disability for fear of discrimination (Lund et al. 2014). In a rare study of disability of psychologists in the UK, numerous challenges were noted for 6 trainees, '*many of which arose from a system which appeared to be aimed at those in healthy bodies' (*Coop, *2018).* Such concerns are not psychology-specific: 18.5 per cent of NHS staff with disability report harassment, bullying or abuse from managers and 25.6 per cent from colleagues (compared with 10.6 per cent & 16.7 per cent respectively for other staff) (WDES, 2022).

Psychologists have expressed many misconceptions including the common myth that everyone must be treated the same, the opposite of that required with respect to disability. This undermines provision of reasonable adjustments. Reasonable accommodation is defined in the UNCRPD (2006) as '*necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms'.* As such, unless provision would impose 'a disproportionate or undue burden', a failure to make an adjustment will likely constitute a denial of human rights under the UNCRPD.

Failure to make reasonable adjustments is a common form of disability discrimination (Select Committee, 2016). Only 76.6 per cent of NHS staff with disability report 'adequate' adjustments to enable them to carry out their work (WDES, 2022), with 'adequate' not a high bar when the right is to work 'on an equal basis' (UNCRPD, 2006). Many adjustments cost nothing and effective and practicable adjustments that involve little or no cost or disruption '*are very likely to be reasonable for an employer to have to make'* (EHRC, 2011a). The statutory guidance is also clear that lack of cooperation from colleagues is unlikely to justify a lack of adjustment. Yet adjustments that cost little and may be inconvenient but not disruptive, are still denied. For a large employer like an NHS Trust, the cost would need to be exceptional for a lack of an adjustment to be justified on cost grounds. For exceptional costs an Access to Work grant may also be sought. This has an annual cap of £60,700 including the employer's contribution (Disability Rights UK, 2023).

Denial of an adjustment that would ease the daily challenge of living, training or working with a disability is extremely frustrating, particularly if one of 18 examples of reasonable adjustments in the statutory guidance (EHRC, 2011a). Would you also find it acceptable as a trainee for a reasonable adjustment not to be provided on the basis of a view that you would likely not receive this adjustment once qualified. I think not. In effect, you would be denied the right to an adjustment now because you might also be denied this right in the future! This is also highly devaluing. The risk to wellbeing is a major concern with a medical consultant and a student noted to have committed suicide after denial of adjustments. Almost all the complaints, grievances and legal actions have had an added detrimental effect. I fear it is only a matter of time before a psychologist commits suicide.

Legal claims, in particular, often include protracted and costly delays over technicalities, a lack of adjustment in legal processes and unjustified (sometimes clinically undermining) disputing of diagnoses, assessment reports (including psychology), disability and needs. Even when the evidence appears conclusive, legal claims seem a lottery. Cases may fail on a legal technicality in spite of a clear denial of UNCRPD rights. In my view urgent action is required to address the underlying concerns and reduce the need for legal action.

The indications are that clinical psychologists have not received adequate training on legal obligations with respect to disability. At the very least we need to prevent unlawful action because of lack of awareness. However, we also have a duty to raise awareness of the rights, dignity, autonomy and needs of persons with disabilities and to promote reasonable adjustments (UNCRPD, 2006) . This is reinforced by the WHO (2022) call for a more disability-informed and skilled workforce to reduce health inequities.

Responding to the WHO call to action

Full implementation of the UNCRPD and EqA requires Government, legal and regulatory body action. However, we can take steps now to meet our professional duty to promote the human rights of persons with disabilities, whilst also responding to the WHO call to action. As such, I suggest the following:

1. ***All practitioners:*** Complete a simple Disability Discrimination Awareness Questionnaire and one or more practice Checklist (for practitioners, service managers and training courses). (For an automated message on accessing these, please email: andytyerman@equitynotjustequality.co.uk (NB If no reply, please check junk/spam).
2. ***All practitioners:*** Address any identified knowledge gaps by reading the relevant EqA statutory code or technical guidance on employment (EHRC, 2011a); services (EHRC, 2011b) and/or further and higher education (EHRC, 2014) and the UNCRPD.
3. ***All practitioners:*** Amend any identified personal discriminatory practices. Challenge colleagues about any apparent discrimination and make reasonable adjustments, in line with UNCRPD, EqA and HCPC requirements.
4. ***Practitioners:*** In line with UNCRPD requirements, review the information and advocacy needs of the clients you work with respect to human rights and reasonable adjustments.
5. ***Managers:*** Read the Employment Statutory Code (EHRC, 2011a), any relevant organisational policies/reports (e.g. NHS Trust's annual Workplace Disability Equality Standard [WDES]) and update practice, as required.
6. ***Training courses:*** In line with the technical guidance (EHRC, 2014), review existing provisions, criteria or practices for any substantial disadvantage for persons with disability and either amend or mitigate through provision of reasonable adjustments.
7. ***Training courses***: review and strengthen training on disability discrimination and on making reasonable adjustments, in line with UNCRPD, EqA and WHO Call for Action.
8. ***Professional organisations/groups***: review and strengthen, as required, standards, policies and guidelines relevant to health inequities and disability discrimination, including the development of specific guidance on making reasonable adjustments.
9. ***Professional bodies:*** It is suggested that practitioners with disability are consulted on the need for examples to illustrate how reasonable adjustments have enabled them to practice psychology (or other areas of healthcare) to challenge negative assumptions.
10. ***Research:*** there is a pressing need for representative research to establish the nature, extent and experience of discrimination by psychologists with disability, as well as the client groups that we see, in order to inform further action.

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Biography

Andy worked in neurorehabilitation from 1979-2021. From 1992 he developed and led the Community Head Injury Service in Buckinghamshire, providing community rehabilitation, vocational rehabilitation and family services. Based on this experience, he contributed to numerous national standards and guidelines in community and vocational rehabilitation after brain injury and other neurological conditions. Whilst retired, Andy remains active in research, supervision, teaching and writing and is also a Trustee of Headway UK and the Vocational Rehabilitation Association.

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