ION

Institute Of Neurodiversity™

4 Models of Disability

And Impact on Neurominority Individuals

This is an overview and comparative analysis of four key models of disability: **the Charity, Medical, Social, and Rights-Based models**, including how they can impact on neurominority individuals (people of minority neurotypes, such as Autism, ADHD, Dyslexia, Dyspraxia, Tourette's, etc.).

This also draws from frameworks referenced by the UN, including the UNCRPD (United Nations Convention on the Rights of Persons with Disabilities) and commentary from agencies such as UNHCR on disability inclusion and protection.

The first part describes each model, the second part shows actual examples and the third part describes why a collaboration across all four is desirable.

1. Charity Model of Disability

Definition:

The Charity Model views disabled people as passive recipients of care, pity, or benevolence. It assumes that disability is inherently tragic and that society must compensate for it through charity, volunteerism, or religious duty.

Key Characteristics:

- Focus on helping or rescuing the person and can offer family support, peer networks, and mentoring
- Assumes dependency.
- Power remains with non-disabled actors or institutions.
- Originates from religious or philanthropic traditions.
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- The community helps advocate for neurominority individuals and provides emotional and practical backing to the parents.

Implications for Neurominorities:

- Neurominorities may be depicted as helpless or broken that need fixing or sympathy.
- Encourages funding for services only when a neurominority person appears “severely impaired.”
- Undermines self-advocacy and peer-led initiatives.
- May fuel stigma and internalised shame by framing neurodivergence as misfortune.

Where it can fall short:

- It takes away agency.
- Reinforces a “deficit” view of the person.
- Creates dependency instead of empowerment.
- Offers no structural critique or pathway to systemic inclusion.

2. Medical Model of Disability

Definition:

The Medical Model treats disability as a clinical diagnosis, a problem located in the individual’s body or brain. It emphasises assessment, treatment, cure and elimination through medical or therapeutic intervention.

Key Characteristics:

- Diagnosis-centered.
- Focuses on impairments and dysfunctions.
- Success is measured by “normalisation ” or reduction of symptoms.
- Power lies with medical professionals and institutions.
- A diagnosis (e.g. minority neurotype) provides a clinical explanation
- It can unlock access to services like speech therapy, occupational therapy, or psychological support.

Implications for Neurominorities:

- Frames neurotypes like autism, ADHD, or Tourette’s as “disorders or conditions.”

- Encourages masking, behavioral therapies, or medication to suppress traits.
- Often pathologises traits that may also be sources of strength.
- Makes access to support contingent upon diagnosis, severity, and “deficit demonstration.”

Where It Can Fall short:

- Ignores lived experience, identity, and culture of neurominorities.
- Overlooks the environmental and social barriers.
- Can lead to forced treatment or harmful interventions (e.g., conversion therapy, ABA).
- Leaves little room for neurodiversity as a natural human variation.

3. Social Model of Disability

Definition:

The Social Model shifts the focus from the individual to society. It posits that people are disabled by social and environmental barriers, not by their differences or impairments.

Key Characteristics:

- Disability is caused by inaccessible systems, attitudes, and environments.
- Focuses on barrier removal and societal change.
- Values lived experience and user-led activism.
- Promotes inclusion through design, policy, and community shift.

Implications for Neurominorities:

- Recognises that challenges faced by neurominorities (e.g., in school, work, or public life) stem from rigid systems designed for neurotypical norms.
- Advocates for universal design, flexible education, inclusive employment, sensory-friendly environments, etc.
- Shifts funding and focus from “fixing the person” to fixing exclusionary systems.

Where It Can Fall Short:

- Originally more focused on physical and sensory disability, less developed in addressing cognitive and social differences.

- May not fully account for the internal and sensory experiences of distress or co-occurring conditions in neurominorities.

4. Rights-Based Model of Disability (UNCRPD-Aligned)

Definition:

The Rights-Based Model frames disability as a human rights issue. It asserts that disabled people have equal rights and are entitled to full participation, dignity, autonomy, and non-discrimination.

Key Characteristics:

- Emphasises legal protection and systemic accountability.
- Upholds agency, voice, and representation of disabled people.
- Enshrined in international conventions, especially the UN Convention on the Rights of Persons with Disabilities (CRPD).
- Recognises intersectionality, identity, and community belonging.

Implications for Neurominorities:

- Supports self-identification and legal recognition of diverse neurotypes.
- Demands accessibility, accommodations, and anti-discrimination laws.
- Upholds the right to inclusive education, employment, healthcare, legal participation, and protection from abuse.
- Challenges practices like institutionalisation, forced treatment, and denial of diagnosis.

Why It Matters:

- Recognises neurodiversity as a valid form of human variation.
- Embeds rights in national and international law.
- Offers a foundation for political, legal, and social change.

Comparative Summary

Model	Focus	View of Disability	Power Lies With	Effect on Neurominorities
Charity	Pity, Help	Tragedy to be alleviated	Non-disabled helpers	Disempowerment, infantilization
Medical	Diagnosis, Treatment	Problem in the individual	Clinicians, institutions	Pathologization, erasure of identity
Social	Environmental & Attitudinal Barriers	Society disables people	Community & activists	Inclusion focus; lacks nuance on internal experiences
Rights-Based	Justice, Equality, Participation	Human rights issue	Disabled/neuro minority people	Empowerment, recognition, systemic protection

Reflection

For neurominorities, the Rights-Based and Social models are the most progressive and empowering. They acknowledge that challenges stem not from our brains being “wrong,” but from systems designed without us in mind.

However, full liberation for neurominorities likely **requires a hybrid model that:**

- Centers **rights and agency**
- Targets **barrier removal**
- Supports **healthcare** when wanted, **not as the primary framework**
- Changes the legacy **of charity and pity** in public perception

Below are four scenario-based examples of how Charity, Medical, Social, and Rights-Based models would respond to the same real-life situation.

Situation:

A 10-year-old autistic child is excluded from mainstream school because their sensory sensitivity leads to meltdowns in a noisy classroom.

Charity Model Response

Core Belief: “Poor child, they can’t cope like the others. We must do something nice for them.”

- A charity might offer special toys, therapy funding, or a place in a “special needs” school.
- Teachers might express sympathy but feel the child needs to be “somewhere more suitable.”
- The school assumes the child’s difference is unfortunate and the exclusion is inevitable.
- Any support is seen as optional kindness, not a right.

The child is removed from their peer group and denied equal education. The root issue (a noisy environment) is not addressed.

Medical Model Response

Core Belief: “The problem is inside the child. Let’s diagnose and treat it.”

- The child is referred for psychiatric or developmental assessment.
- Solutions proposed include medication, behavior modification (e.g., ABA), or therapy to “manage symptoms.”
- The school may require a diagnosis before offering accommodations.
- Emphasis is placed on reducing meltdowns, not on changing the environment.

The child is pathologised, and responsibility is shifted away from the system. The focus is on fixing the child, not the school.

Social Model Response

Core Belief: “The environment is disabling the child, let’s fix the barriers.”

- The school conducts a sensory audit and reduces noise, changes lighting, and offers quiet zones.

- The child is offered flexible routines and alternatives to stressful situations.
- Staff are trained to understand autistic communication styles.
- Exclusion is seen as a failure of the system, not the child.

The child remains included by adapting the environment. However, access to these changes may still rely on goodwill or funding.

Rights-Based Model Response

Core Belief: “The child has a legal and moral right to inclusive education.”

- Exclusion is treated as discrimination under education and equality laws.
- The school is required to make reasonable adjustments under legal duty.
- The child and their family are empowered to appeal, with advocacy support if needed.
- The student’s voice is included in decisions about their education.

It combines the social model’s barrier removal with legal enforcement and respect for the child’s autonomy. Inclusion is not a favor — it’s a right.

Summary Table

Model	View of the Child	Response to Exclusion	Outcome
Charity	Pitied and helped	Offers sympathy, charity school or donations	Segregated, reliant on external goodwill
Medical	Diagnosed and treated	Focuses on correcting behavior or symptoms	Possibly returns to school, “managed”
Social	Disabled by the system	Changes the school environment and teacher approach	Included through adaptation
Rights-Based	Entitled to equal education	Challenges discrimination, enforces rights	Fully included and protected

Scenario 2:

Employment:

Autistic adult dismissed after struggling in open-plan office

A 32-year-old autistic employee is dismissed for “not fitting into the team culture” after experiencing sensory overload and communication misunderstandings in an open-plan office.

Charity Model Response

> “It’s unfortunate, but maybe someone can help them find a more suitable job.”

- A charity might offer a sheltered workshop or job-coaching service.
- The person is viewed as unable to work in a ‘normal’ setting.
- The employer may make a donation to disability causes to feel better.

It reinforces segregation, views the person as incapable, and places no obligation on the employer to change.

Medical Model Response

> “They need treatment to function better at work.”

- The employee is referred to occupational therapy or counseling.
- May be prescribed medication for anxiety or sensory issues.
- HR might require formal diagnosis before discussing adjustments.

Assumes the person must adapt to the environment rather than vice versa; dismissal is still justified if “treatment didn’t work.”

Social Model Response

> “The workplace setup is the problem.”

- The employer reviews lighting, noise, and social norms in the office.
- Offers noise-cancelling headphones, flexible work-from-home options.
- Provides neuroinclusion training for managers and colleagues.

The environment is changed to be more inclusive, but support may be inconsistent if not backed by policy.

Rights-Based Model Response

"This dismissal is likely discriminatory."

- The employee is supported in taking legal action under equality law.
- Workplace adjustments become a legal duty, not a favour.
- The employee has access to advocacy and union support.
- Company policies are restructured to prevent future exclusion.

It enforces accountability, protects rights, and supports structural change.

Summary Table:

Employment

Model	View of Employee	Response to Exclusion	Outcome
Charity	Pitied, offered a low-demand job	Offers alternative job in a separate setting	Marginalised, removed from mainstream
Medical	Diagnosed and treated	Seeks to modify person's behavior	May return or remain excluded
Social	Excluded by workplace barriers	Adapts office environment and practices	Included if employer willing
Rights-Based	Entitled to workplace inclusion	Holds employer accountable under the law	Protected, empowered, and included

Scenario 3:

Healthcare:

ADHD adult denied diagnosis due to “coping well enough”

A 26-year-old person suspects they have ADHD after years of struggling with focus and burnout, but is told they are “too high-functioning” to need a diagnosis or support.

Charity Model Response

“We’ll offer emotional support while they wait for someone to help.”

- A charity helpline might offer a listening ear or pamphlets.
- The person is encouraged to keep trying and seek informal support.
- But there’s no pathway to diagnosis or formal accommodation.

It treats the situation as a sad circumstance, not a rights issue, and fails to address systemic exclusion.

Medical Model Response

“Only if symptoms are severe enough do they need treatment.”

- The individual is denied assessment due to masking or academic success.
- Diagnosis is tied to visible dysfunction, not lived experience.
- Focus is on gatekeeping access to medication, not holistic support.

The model excludes people who have adapted outwardly but are still suffering internally. Masking is rewarded.

Social Model Response

“The problem is that services aren’t built for their needs.”

- Pushes for flexible, person-led assessment processes.
- Highlights that individuals and marginalised groups are often overlooked.
- Advocates for community-based diagnostic pathways and peer networks.

Shifts focus to service barriers, but can lack enforcement or funding if not tied to rights.

Rights-Based Model Response

“Access to healthcare and diagnosis is a human right.”

- Systemic gender bias in diagnosis is challenged as a rights issue.
- Clear standards for timely, inclusive access to diagnosis are established.
- Individuals have legal avenues to appeal or lodge complaints.
- Their identity and access needs are validated and supported.

It guarantees access, challenges systemic bias, and upholds autonomy.

Summary Table:

Healthcare

Model	View of Individual	Response to Denial	Outcome
Charity	Struggling but unsupported	Offers emotional sympathy, little else	Unacknowledged, still excluded
Medical	Not “ill enough”	Denied diagnosis or medication	Needs dismissed, support withheld
Social	Excluded by service design	Advocates for systemic flexibility	May gain access, but inconsistently
Rights-Based	Deserving of equitable access	Challenges systemic bias, enforces access	Protected, empowered, supported

Scenario 4:

Criminal Justice:

Autistic teen arrested for “non-compliance” during police stop

A 15-year-old autistic person is arrested after freezing and avoiding eye contact when stopped by police. Officers interpret this as suspicious and non-compliant behavior.

Charity Model Response

“Let’s support them through this difficult experience.”

- A youth charity may offer support or mentorship during the legal process.
- The system itself is not challenged.
- The teen is seen as vulnerable but not as someone whose rights were violated.

Doesn’t question police behavior or systemic injustice. Offers support after harm.

Medical Model Response

“They should have a care plan or behavioral label to avoid this.”

- Recommends the child carry documentation of their diagnosis.
- May suggest therapy to reduce “confrontational” behaviors.
- Doesn’t change how police interact with neurodivergent/neurominority youth.

Places responsibility on the child to adapt to authority rather than addressing policing norms.

Social Model Response

“The justice system is not designed for neurodivergent youth.”

- Advocates for neurodiversity training for officers.
- Pushes for sensory-appropriate holding environments and interview techniques.
- Suggests diverting youth from custody to support programs.

Pushes for systemic reform and new protocols, but change is often slow and discretionary.

Rights-Based Model Response

“This is a breach of rights and discriminatory policing.”

- Challenges the arrest as a violation of disability and human rights law.
- Demands accountability, independent review, and systemic reform.
- Supports legal action and compensation.
- Promotes the child's voice and advocacy throughout the justice process.

Shifts power back to the individual and demands institutional change.

Summary Table:

Criminal Justice

Model	View of Youth	Response to Incident	Outcome
Charity	A tragic case needing sympathy	Offers support services, but no change	Harm not prevented or addressed
Medical	Needs labelling to avoid trouble	Suggests documentation or therapy	Blames individual, not the system
Social	Disadvantaged by the system	Advocates for reform and training	Helps future cases, but not always enforced
Rights-Based	Victim of discrimination	Enforces rights, demands accountability	Empowered, systemic change pursued

Collaboration across all four models is helpful

One can argue persuasively that all four models of disability (charity, medical, social, and rights-based) have value in different contexts, and when combined thoughtfully, they offer a holistic, multi-dimensional understanding that can drive better outcomes. Rather than seeing them as mutually exclusive or hierarchical, a **collaborative and integrative model** can be more effective, especially when addressing complex, real-world situations like those experienced by neurominorities.

Why a Holistic Use of All Four Models Can Be Valuable

Each model addresses different layers of reality:

- Charity model recognises the need for empathy, community support, and often serves as the emotional/motivational driver for action.

- Medical model addresses biological or clinical realities, often necessary for treatment, diagnosis, and some forms of access to support.

- Social model identifies and challenges systemic barriers, enabling environmental and structural change.

- Rights-based model ensures legal protection, autonomy, and empowerment, anchoring the other models in enforceable justice.

A Realistic Example Where All Four Apply:

A 14-year-old autistic student is being excluded from school due to behavioural challenges misunderstood by staff.

Medical Model

- A diagnosis (e.g. autism) provides a clinical explanation of the student's sensory processing or executive functioning challenges.

- It can unlock access to services like speech therapy, occupational therapy, or psychological support.

Social Model

- The school environment is revealed to be inaccessible, perhaps it's noisy, unstructured, or staff lack neurodiversity training.

- Changes like quiet spaces, flexible timetables, or teacher training help remove disabling barriers.

Rights-Based Model

- The exclusion is challenged under educational rights laws (e.g. the Equality Act in the UK or IDEA in the US).

- A formal complaint may be made, demanding the child's right to education and reasonable accommodations.

Charity Model

- A local autism charity steps in to offer family support, peer networks, and mentoring.

- The community also helps advocate for the child and provides emotional and practical backing to the parents.

Cross-Sector Collaboration

- Medical professionals provide insight and evidence to shape support plans.
- Educators and administrators adjust the environment using social model principles.
- Legal advisors and advocates ensure policies and protections are upheld.
- Charities fill in gaps with flexible, person-centred help and awareness-raising.

Conclusion

The integration of all four models:

- Encourages cross-sector collaboration instead of isolated action
- Balances empathy, evidence, environment, and enforcement
- Respects the person's agency while addressing real-world barriers
- Avoids reductionism and allows space for nuance and dignity

This approach is particularly valuable for neurominorities, whose needs are often misrepresented or oversimplified when just one model dominates.

ION advocate for collaboration between all parties working and living within the neurodiversity space. When we collaborate across all ways of helping us, we will get things more right. Most actors in neurodiversity are ultimately aiming for the end goal of making our lives better. When we do that together more needs can be met.