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CHAPTER 4

Pupil or 'Patient':  
difference, disability and  
education in France

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This chapter attempts to use the social model and the medical model as contrasting lenses through which to begin to analyse the French education system and how it responds to 'difference'. My starting point is an interest in the processes of exclusion and inclusion in education, in their many and disparate forms. These processes do not begin and end in easily identifiable ways. They are historically rooted and spread into all aspects of social, economic and political life, so it is impossible to draw a boundary around something called 'the education system' and to treat it as separate from the broader landscapes of social life. This is quite clearly demonstrated in France where some disabled children and young people are 'not counted' as being members of the education system at all. They are denied the social role of 'pupil' on the grounds of impairment and deficit-driven perceptions of difference. The French regional newspaper *la Dépêche du Midi* (26.01.03) challenges this exclusion of disabled people:

Because of impairment, many children continue to experience forms of discrimination and rejection and their education is restricted and considered as of secondary importance. How can we energise the system and awake the collective conscience? Must we legally force institutions to practice integration? What is the credibility of a school which excludes (children) at the same time as it claims to be against exclusion?

Citing Charles Gardou, director of the department of education at the Université Lumière, Lyons, the article continues:

Today there are 40,000 children who are not receiving education, which means that the right to education for all is not yet assured

in this country, for we are (locked into) a culture of *intention; we do not act*. What right have we to deprive anyone of the right to knowledge? We should allow every person to develop in their own way: two children who (happen to) have the same impairment, are not *the same*. Everybody is unique. (*my emphasis*)

### ***Practices of removal***

The act of assessment and diagnosis is a routine part of practices of removal and the construction of disabling barriers to participation in ordinary social life. These barriers are socially produced and spatially legitimated. They do not emanate from the characteristics of individual children or young people – on the contrary, they are derived from societal attitudes, power relations and particular constructions of privileged knowledge. They are linked to financial imperatives and bureaucratic rigmarole, to narrow constructions of normality embedded in psychological testing, to the design and organisation of the environment and to the shortcomings of education systems.

Although I focus particularly on the *external* structures and processes of exclusion here, the interpretation of the social model I am drawing on recognises the importance of the interplay between the 'public' and the 'private' which provides depth of meaning to the notion of exclusion. This relates to the social relational model of disability (Thomas 1999) described as including:

both structural and psycho-emotional dimensions of disability (in which) disability is seen as a form of social oppression that operates at both the public and personal levels, affecting what people can *do* as well as who they can *be* (Reeve 2004:83).

In France – as elsewhere – the exclusion of disabled children and young people has a profound effect on what it means for those who make up the school population to be a pupil, or rather it defines what a school pupil can *be*. The values and assumptions underpinning the exclusion of any group of students for whatever reason, infuse the cultures, practices and student identities in all schools, implicitly and complicity, not least in terms of the imposition of particular versions of normality and particular models of humanity and citizenship.

Disabled children are confronted on a daily basis with ways of speaking about disability that influence their experience and their sense of identity. Negative portrayals of disability abound and disabled children in particular have been subject to

institutional discourses of tragedy, medicalization and otherness (Priestley 1999: 93).

These processes affect the world-view of *all* members of the community, including those of pupils in schools in which disabled children are absent.

There is currently a major reappraisal of the education system taking place in France, encompassing a wide span of sectors including all age ranges and higher education, as well as its aims and values. In 1999 the 'plan Handiscol' - an initiative focusing on education and disabled children and adolescents - was established, managed by the ministère de l'éducation nationale (the Department of Education) in close collaboration with the ministère de l'Emploi et de la Solidarité (the Department of Employment and Solidarity). Its purpose is to improve the education system and, in particular, the widening the participation of disabled children and young people in ordinary education settings. This has provided a forum for debate and the development of policy, as well as more immediate initiatives such as the setting up of a national information helpline for the families of disabled children which provides information and advice about rights and services.

The Handiscol initiative has made an important contribution to the wider debate on issues relating to education and the rights of disabled children. This debate has clarified distinctions between a 'soft' approach which sees widening participation in ordinary schools as 'desirable' and the more deeply political position which problematizes issues in ways which are more challenging to dominant policies and assumptions. Plaisance (2005) cites the example of the position taken by the Association for Disabled Adults and Young People (Association pour adultes et jeunes handicapés - the APAJH) which has systematically opposed the way in which 'integration' has been presented in official texts in terms of being 'desirable' or something to be 'favoured' rather than as an obligation. The APAJH argues that disability issues should not be posed in terms of *integration*, which presupposes that a disabled person is an 'outsider' or 'comes from the outside', but that questions should be situated within a critical debate about exclusion. An important consequence of this is the affirmation of the right of education *for all*, and the obligation placed on schools to recognise this. This position necessarily poses the necessity of a concrete realisation of the fundamental principle of 'equalisation' at all levels, including in terms of support and the transformation of the environment (Plaisance 2005).

An important piece of legislation relating to disabled people is being discussed by parliament - the law concerning 'Equality of rights, opportunities, participation and citizenship of disabled people' (*Pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées*). The proposals under discussion are based around 4 main principles:

- Freedom to choose for disabled people in terms of home, family, social and professional life so that their desires and aspirations are respected.
- The right to 'compensation' for 'the consequences whatever they are of disability' and to provide the financial conditions for disabled people to live autonomously 'with dignity'.
- The right to participate in social life, including providing access to education, employment, buildings and transport.
- The simplification of procedures and the setting up of a system of advice and personal guidance which will allow disabled children and their families straightforward access to new opportunities and possibilities.

If the changes in opportunities and practices which work their way into people's lives reflect the principles outlined above, they are to be welcomed. However, there are two important issues which require consideration. Firstly, it appears that although all children have a right to be enrolled in a school in their neighbourhood, it does not follow that they will not then be placed in a special school if there are 'explicit and recognised reasons for doing so'. Secondly, there are questions which need to be raised about the notion of compensation when this is couched in terms of offsetting the effects of impairment rather than removing the practical barriers to participation, although the proposals *are* explicitly concerned to 'compensate' for these by removing structural and financial barriers. One embedded assumption underpinning the notion of compensation for *impairment*, rather than in response to *institutionalised discrimination*, is that it locates the 'problem' within the individual rather than within society. Historically, this 'individual model' has been closely associated with segregated special education, and this is often still the case (Boxall 2002). There appears to be a blurring of the two positions in current debates: society has a duty to compensate individuals on the basis of their impairments *and* remove structural and financial barriers to participation.

In the sections which follow I will explain how I am interpreting the

medical and social models of disability and examine their usefulness in understanding the history and processes of inclusion and exclusion in the French system. In the context of this chapter, 'implementing' the social model means using it as an approach to exploring and providing fresh insights for understanding and interpreting.

### *The advent of the medical*

I will take as my starting point Bill Hughes' description of the medical model and its origins:

For disabled people the legacy of modernity was one of invalidation. This originated in the processes that excluded 'impaired labour power' from the work-force and in medical systems of classification in which disability came to mean a 'faulty' or abnormal body. A disabled person was a victim of that cruel whim of nature or circumstance and became the kind of person that her body allowed her to be. The barriers to citizenship, to living a full and active life, were - tragically and unfortunately - physical and internal. The ontological essence of disability was impairment. For example, with respect to people with mobility impairments, the medical model suggests that 'their immobility is their own fault or the consequence of deviant corporeality which requires medical care, or, failing that, the application of charitable works' (Imrie 2000: 1652). (Hughes 2002: 63).

The history and organisation of responses to impairment in France in many ways demonstrate this description very clearly. With the development during the nineteenth century of modern, industrialised approaches to managing masses of people, and the rise and rise in the status of the physical sciences and the medical professions, the identification and care and control of those who were deemed 'unproductive', disturbing, destitute, criminal or sick, led to increasing numbers of people being brought together to be treated and managed.

Responses to disability, difference and non-conforming others have, historically, included the systematic segregation of groups of people from the rest of society. In 1793 Philippe Pinel released eighty-nine 'lunatics' from their shackles and began to 'treat' them, marking a move away from a purely custodial model towards a medical model of care and treatment. This event was symbolic in that it heralded an epoch of diagnosis and the categorization of conditions and impairments and the use of these

categories as a basis for placement and therapy. The twin projects of management and care, which became increasingly mediated by the state, continue to coexist as social and political responses to difference in all so-called 'western' societies today. These responses are, in turn, formulated and rationed, explained and rationalised, according to changing values, variations in political climate and in the light of different agendas and decisions about the use of resources.

Pinel's work ushered in new practices of care and therapy, based on a changed perception of difference in which the person was no longer regarded as possibly dangerous, out-of-control, useless, the subject of derision, but as an individual human being whose difficulties could be reduced through the application of medicines and therapies (Armstrong 1996).

The importance of understanding historical developments with all their discontinuities and contradictions as one means of illuminating current practices and struggles cannot be underestimated. Today in France placements of children in particular institutions designated for some conditions or impairments may still require a medical prescription. Similarly, in England, medical assessments frequently still play a major part in procedures relating to assessment and educational placements.

Mass, compulsory primary education was introduced in France in 1882 and later extended to the secondary stage. The special institutions which were set up separately from the state education system had primarily therapeutic or medical aims. This division between an education system for pupils and a separate medico-social network of structures and professions destined to contain, care for and treat 'patients' - children and young people classified as having an impairment, or being socially deficient or difficult to control - has characterized the French system for well over a century and presents a monolithic obstacle to change. This obstacle exists at a number of levels, including:

- The rigidity of the education system in terms of its organization, curriculum and ethos.
- The existence of legislation, in which policies made in one domain are contradicted by existing legislation and practices in another (e.g. policies made concerning education may be overridden by unchanged policies and structures in health and social services).
- Attitudes in which impairment-led ways of seeing are legitimized by the continued placement of many disabled children in institutions outside the education system.
- At the level of teacher professional development. Teachers working

in specialized settings, either within the education system, or outside it - receive specialist, impairment based training in 'special education' or a named impairment, while the professional development of mainstream teachers does not prepare them to teach a wide diversity of learners or to work in multi-disciplinary teams.

These socially produced 'separations' illustrate the argument contained in the social model that material, cultural and systemic conditions create inequalities and barriers to participation and are based on an individual-deficit view of difference. The social model as described by Barnes (2003) can help us to understand the contingent, socially produced nature of barriers to participation in the French context because it draws attention to:

the economic, environmental and cultural barriers encountered by people viewed by others as having some form of impairment. These include inaccessible education, information and communication systems, working environments, inadequate disability benefits, discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities, and the devaluing of disabled people through negative images in the media - films, television and newspapers (Barnes 2003: 9).

### **Inclusion and exclusion in education**

The situation in France is illustrative of the irreconcilability of the medical and social models. It represents the antithesis of, for example, the principles of inclusive education embodied in the Salamanca Statement (1994) which proclaims:

Schools should accommodate all children regardless of their physical, intellectual, emotional, social, linguistic or other condition (Article 3).

Regular schools with this inclusive orientation are the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all (Article 2).

The exclusion of disabled children and young people from education has been the focus of legislation at different stages since the passing in June 1975 of the *Loi d'Orientation en Faveur des Personnes Handicapées* which purported to present 'handicap' - as a social disadvantage, rather than an individual deficit. During the period between 1950 and 1970 there was a proliferation in the large network of 'médico-éducatif' establishments

outside the education system. By 1975 there was a general awareness that this system segregated young disabled people from the rest of the community. In response to this change in attitude the *Loi d'Orientation en Faveur des Personnes Handicapées* declared the right to social integration of all children, young people and adults identified as having physical, sensory or mental disabilities. It recorded the right to education, training, work and financial support and laid down the structural and procedural changes which would enable and facilitate increased participation of children and young people in ordinary schools. The law stated that children should where possible be admitted to ordinary schools 'in spite of their handicap'. However, the large and complex network of special schools and institutions and the intractable nature of the ordinary school ethos and curriculum remained, acting as a major barrier in terms of breaking down old systems and practices.

A report on the education of disabled children and adults in France published by the Directorate of Research and Evaluation and Statistical Studies (DREES 2003), headed by representatives from the Ministries of Education and Social Affairs and Health, contains some illuminating material. One point that is made is the difficulty in obtaining accurate information concerning disabled children who live at home and do not attend schools run by the Ministry for Education. There is unease that some children may be untraceable in terms of whether they receive any formal education at all, and what this may comprise.

The statutory starting age for formal education is six. In practice, education usually enrolls at three or four years of age with over 95 per cent of children attending nursery schools which are free, and an integral part of the education system. At this stage the gates open wide and many children participate in ordinary groups, but are later removed to specialist settings. Approximately 52,000 disabled children and young people are integrated on an individual basis in ordinary schools, and 50,000 attend specialist classes or units within the education system, but the vast majority of these are in the primary sector because there are very few specialist units at the secondary level. When the professionals involved consider that placement in the ordinary education system is 'not possible' children are directed towards the medical-social structures, outside the education system. It is difficult, perhaps impossible, to actually gather together information about the whereabouts of children in the system. However, according to the DREES report, 115,000 children attend medical-social institutions and only 58 per cent of these receive a full-time education.

17 per cent are integrated into ordinary schools run by the Ministry for Education on a full or part-time basis. Nearly 25 per cent of disabled children who attend settings outside the state education system, are not 'scolarisé' – that is to say, from a formal point of view they are not receiving any schooling; this percentage reaches 94 per cent for children and young people who have what are described as multiple impairments, and 78 per cent of children deemed to have severe learning difficulties. In theory, parents have the right to insist that their child attends an ordinary school but, it appears, this is rarely evoked or exercised. A deeply embedded system of support and guidance and the omnipotent weight of professional opinion all work against the empowerment of families and children themselves in the decision-making process.

### ***Researching structures***

One of the difficulties in trying to understand a whole mass of social structures, values and practices as they work together to produce the social conditions and relations in which inclusions and exclusions occur, is the challenge of recognizing the unevenness of the terrain and the contradictions and discontinuities which arise. In my research in France between 1997–2000 into the ways in which policies are interpreted and make their way through systems, I explored policies and practices in a number of different schools and institutions in an attempt to understand the processes through which children and young people find themselves in one setting rather than another. The three settings briefly discussed below represent very different perceptions and values regarding rights, difference and disability, and show some of the possible extreme contradictions which can co-exist within one national system. Some of the material in this section is taken from my earlier research – *Spaced Out: Policy, Difference and the Challenge of Inclusion* (Armstrong 2003) where a fuller description and discussion of the settings can be found. In the account below, I have decided to use the terminology which is used in the different contexts themselves and which is recorded in the transcripts I made, although it should be borne in mind that I have translated this into English. I have put extracts taken directly from the interview material in quotation marks. The purpose of preserving the discourses used is to indicate the pervasive use of medical or pathologizing labels and their embeddedness in particular settings, as well as to show examples in which alternative values and interpretations are at work. It is particularly interesting to note the contrast in the ways children and young people are perceived in the different

settings through the lens of the discourses used and the contrast between the 'medical' and the 'social'.

The 'Hôpital Sainte Thérèse', a large medical complex, is the site for the National Institute for Re-adaptation (Institut National de Réadaptation). All the children who attend the Institute at the Hôpital Sainte Thérèse have been admitted to the hospital for medical treatment. Those who are well enough and old enough are enrolled in educational programmes. The National Institute for Re-adaptation has three distinct sections, A, B and C. Service A is for children who have 'suffered some kind of brain injury as a result of accident or a stroke or after an operation for a tumour'. The orthopaedic service - Service B - is designated for children who have all kinds of problems relating to 'congenital orthopaedic pathologies requiring a programme of re-education with a great deal of physiotherapy which can only take place in a hospital'. Sector C is 'for children who have suffered neurological problems from birth, including cerebral palsy or other congenital neurological problems which are hereditary in origin and are usually very seriously handicapped - often paraplegic, or tetraplegic, without speech and with very restricted motor control'.

The school provides education for children from all three services. Approximately 160-170 children and young people are patients at the National Institute for Re-adaptation and about 140 of those are on the role in the school or attend the kindergarten. The others are not deemed well enough to receive education. While in the past, the period of care at the centre could be anything up to twelve or thirteen years, this period has been reduced to between four weeks and four years. There is residential provision for children requiring 24-hour medical care and for those whose homes are some distance away from the centre.

As far as the teaching staff at the centre are concerned, their role is primarily educational and, while differences between students are taken into account including the effects of any impairment, the curriculum and teaching are based on what goes on in ordinary state schools (in contrast to the third French setting discussed in this chapter). Teachers at the centre are fully qualified teachers and have additional specialist training. Other members of staff who work there are also highly specialized in different therapeutic disciplines.

The second setting, the 'Lycée Bresson', is a large secondary school which is part of the state education system. At the time of my visit there were 250 students at the Lycée, and over two thirds were categorised as disabled. 40 per cent of the students had 'impairments associated with

cerebral palsy: other impairments were related to paralysis, brain injury, genetic factors, and a range of other conditions'. The school is lively and welcoming, throbbing with life and energy. Many students were using wheelchairs to get around; others were using technology to communicate. The outside recreation area and the inside circulation areas can be merged to form one large space through the use of enormous sliding glass walls which link 'outside' to 'inside'. The director explained the rationale for this:

We have brought 'outside' into the building. We didn't want a situation in which everybody is crowded together unable to circulate. That's bad for everybody but there are particular problems when you have large numbers of people using wheelchairs who are trying to get to lessons or go and meet their friends. So as you see, there are no corridors - we've got these large common spaces - like avenues or freeways. As you see, we get a lot of speeding!

Although, like the National Institute for Re-adaptation, the Lycée is attached to a medical campus and there are teams of medical and therapeutic staff attached to the medical wing, the focus of the school life and ethos is not centred around the 'medical' but on the social and educational interests of the students and staff:

This is a school like any other. Impairment is a secondary issue. In special schools all the teachers are specialized in terms of learning difficulty or specific impairment. Here, the teachers are ordinary, highly qualified teachers. There is an important 'centre de soins' (medical centre) here which is the responsibility of the Ministry for Health and Social Affairs. Teachers come here because they say they want to work here. They are not 'special' teachers and don't have any specific training. The principle is that all the young people here are students, without exception (School Director).

Although the medical centre operates quite separately from the school, there is a commitment between teaching and medical staff and students themselves to work collaboratively together to counterbalance the effects of physical impairments so that students have 'full access to the curriculum'.

There is a strong emphasis on sport and 'physical prowess' and 'grace', which are seen as belonging in different ways to all those who make up the school community. I watched students playing golf, climbing an artificial rock-face and enjoying a very fast basketball game. In each case

students worked collaboratively but always with apparent determination to win. What might be regarded as 'small triumphs' in another setting, were celebrated by all participants in recognition of achievements of particular students. All sports activities were mixed gender, and members of staff could participate as well.

Another unusual feature of the Lycée is the presence of disabled teachers, one of whom explained the relationship between 'the medical' and 'the social' in ways which suggest a way forward in terms of resolving what is sometimes presented in debates around inclusion as a 'clash of interests' between the medical requirements of students and their education:

There are some very disabled young people here, many of whom would usually attend a specialist institution outside the education system. This means that they are shut off from the ordinary community and don't have the same opportunities as everybody else. Some need a lot of medical input of various kinds, and that's available here. This means that the students have everything they need on one site. This is the reverse of the usual situation in which you have a kind of medical institution with classes attached. The emphasis here is on the education not the medical side. But without the medical centre, some of the students couldn't come here. Also, here, being disabled, requiring medical care sometimes or some kind of therapy or medication is just accepted as 'everyday'. It's not a big deal and is certainly not used as a reason for treating students differently in terms of their education and social life.

The differences between the National Institute for Re-adaptation and the *Lycée Bresson* are to be found in the reversal of emphasis in terms of the relationship between 'the medical' and 'the social', and in the way in which students are perceived and represented, and power exercised. This is evident in the kinds of discourses used in the two settings. Subtly, but powerfully, there is a real sense in the *Lycée Bresson* of a participatory and shared project in which no-one imposes 'solutions' on others, but one in which individual and collective projects are developed collaboratively and in which the voice of students are clearly heard.

The third example is a setting outside the education system. Such institutions vary a great deal in terms of the emphasis placed on *scolarisation* (schooling). In the case of one setting I visited, an *Institut Médico-Professionnel* (IMPRO) which is designated for children and young people

aged between 5-19 identified as having 'psychological and psychiatric difficulties and associated learning difficulties' or as 'too delicate' or 'too vulnerable' to attend school, some young people do not receive any formal teaching in the sense of following a curriculum or having lessons with a qualified teacher. There are three primary trained teachers for 74 children and young people. Only 51 of these attend formal teaching sessions, the others work individually or in groups with psychiatrists, psychologists or with an '*educateur*' (someone trained to work particularly on the social and emotional development of children, as well as their intellectual and creative development.).

The *Institut Médico-Professionnel* is a large, rickety building which has seen grander days. Only two rooms are devoted to formal education and the teacher-in-charge has put a hand-written sign up over a door saying 'School'. Nobody attends the school on a full-time basis because they attend workshop and therapeutic activities, and receive 'treatment' of different kinds. The amount of time a child spends in school varies; some just come for two and a half hours a week, others for several full days.

Many of the pupils have attended ordinary schools in the past, sometimes for many years. Their removal is often explained on the grounds that specialist services such as psychiatry are only available in specialist institutions, so in order for a child to have intensive therapy of this kind, it is necessary for them to leave their school.

The teacher-in-charge pointed out that in 'ordinary structures' specialist help is 'not available' to children and young people with complex psychological difficulties and the emphasis placed on getting through the curriculum and reaching academic targets leads to their removal to settings outside the education system. She explained that most of the group experienced 'severe psychological difficulties'; others experienced difficulties such as 'communication problems', 'mild cerebral palsy' or 'suffered from anorexia'. Some are children or young people who have been taken into care, others have been declared 'too disruptive' to stay in ordinary schools. The teacher-in-charge described the struggles which took place between the pathologizing, deficit-driven identities ascribed to some of the children by psychologists and therapeutic staff with her own view of her students:

There are two different ways of understanding the role of support. One is liberating and it is based on a perception of one's role which says 'This student is progressing. She's going forward because she understands what she is doing'. The other view of

support is about control and says: 'she's making progress because I am there. Her progress is because of me.'

I want to support the young people by opening out new experiences for them. That is why I have developed the integration programme with the local college and it's going well. But I've met a lot of resistance from some others, and from this psychologist in particular. When S.F., one of the young people in my class, said to us 'I want to try and be part of that,' the psychologist said to me: 'Be careful. She's very fragile. Anything might happen'. Well, I'm an institutrice, but when I hear the psychologist say 'she is fragile' that means he is saying 'she is incapable. Anything can happen! She might go completely crazy. She needs protection' and it opens up all sorts of fantastic scenarios. It's very dangerous. These two views of 'support' are totally opposed and they are played out like night and day in the institution (Armstrong 2003: 159).

This quotation illuminates the clear divide between the medicalised, pathologized gaze of some professionals towards the young people 'in their care' with the perceptions of a teacher about her students: young people going forward, with much to do and contribute - young people who must be allowed to be part of the wider community, take risks and explore boundaries, and their own possibilities. It also demonstrates how there can be profound differences between the groups and individuals working within the same setting. It shows how institutions, cultures and practices can control what people can be as well as what people can do (Reeve 2004).

## **Conclusion**

One of the challenges of exploring different cultural settings is to try and become sensitive to one's own preconceptions and assumptions, and the kinds of conceptual frameworks we work with. In comparative work it is always tempting to iron out differences, or to make gross generalizations about countries so that we can find ways of talking about them which are economic and manageable. While it is understandable that we notice apparent extremes in terms of differences between 'other' systems and 'our own', there is a danger of latching on to these and highlighting them as 'typical' examples of, say, the ways in which exclusions take place, disregarding other aspects of that society in which, perhaps, inequalities are challenged. We may not recognize these because we are not looking for

them. It is easier, for example, to say – as many have – ‘France is a prime example of the medical model at work’, rather than exploring counter-examples of this statement, and examining contradictions. A related challenge is that while it may be relatively easy to document the most evident structural causes of oppression and exclusion in different societies, it is extremely difficult to explore the contradictory micro-levels of social-relational interactions and position taking inside institutions.

We need to understand the complexity of working across cultures, particularly in relation to language and the danger of making assumptions based on simplistic translations which fit familiar, culturally embedded concepts and terminology. That said, and always remembering that my interpretation is as ‘culturally embedded’ as anybody else’s, France does seem to be historically burdened with particularly deeply rooted categorical thinking at the different levels of policy making. Paradoxically, this has its roots in progressive thought and the age of enlightenment in which ‘science’ was seen as able to address personal and social ills, by processes of assessment, identification and intervention. Thus, earlier periods of liberal humanitarianism, republicanism and scientific work have left a gargantuan legacy of structures, values and categorical thinking, much of which is shared, at least to some extent, by other contexts, including the UK.

The social model and the medical model, when used as contrasting lenses through which to explore familiar and unfamiliar contexts, are powerful and penetrative in that they allow us to explore physical, social and bureaucratic structures and services and different discourses, policies and practices at different levels in society. Used together, they reveal the distinctiveness of the two models, but also areas and contexts where they might overlap or both be working their way through systems and practices at the same time in a process of struggle and realignment.

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