

2018-08-24

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<http://hdl.handle.net/10026.1/13108>

10.1007/978-981-10-5338-2_15-1

Springer, Singapore

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Bullying, Disability & Chronic Ill-Health

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Abstract

This chapter considers how and why people with disabilities, impairments and chronic ill-health report being subjected to bullying at work. Against a global environment that is reporting increases in working-age, elongated access to workplace pensions as well as a growth in insecure work, workplaces of the future are increasingly likely to encompass increasing numbers of workers who are more likely to have some form of impairment or chronic ill-health. Aside from gender and race, workplace bullying researchers have generally been slow to embrace diverse workplace populations with very little data on the experiences of people classified as holding impairments or chronic ill-health. These populations require careful research designs sensitive to their situations and mindful of how bullying at work can manifest in their lives. Our chapter sets out some of the challenges facing researchers operating in a political-social landscape that currently locates the disabled and chronically sick as a cost to be managed. In maintaining the tradition of trying to make workplaces fairer and more dignified in their treatment of workers, our chapter sets out some of the challenges of seeing disabled people as ordinary human diversities rather than pathologies.

Keywords: *Bullying, Disability, Discrimination; Chronic ill-health; Impairment; Social & Medical Models of Disability; Hate Crime; Reasonable Adjustments/Accommodations.*

Introduction

This chapter addresses an area of workplace bullying that hitherto has been largely under-reported and under-researched, namely employees who are disabled and/or have chronic health conditions. Workers in the early part of the 21st century are discovering a changing occupation landscape with greater levels of uncertainty associated with more insecure forms of employment (Siegmann & Schiphorst, 2016), with elongated working lives because of delayed access to pension entitlements (Gratton & Scott, 2016) and in some cases, such as the UK, a concerted drive by successive governments to drive down the sickness benefits budget by forcing the chronically sick away from state benefits and into the workplace (Mawdsley & Lewis, 2017). Combining such factors with an estimated 470M of the world's working population currently classified in some way as disabled (Equality at Work – the Continuing Challenge, ILO, 2011), creates changes that are likely to find the modern workplace highly populated with older, but not necessarily fitter and more able workforce.

In this chapter, we set out to raise consciousness amongst researchers, practitioners, employee advocates in trades unions and occupational services such as counselling/well-being, of the often-hidden question of disabled and chronically sick workers and how and why they might be exposed to workplace bullying. We use the term bullying as a composite for harassment, emotional abuse and workplace ill-treatment. Whilst the authors are all UK-based researchers and draw heavily from a UK and European context, we take as broad an understanding of disability as possible – particularly as to how disability is defined and the challenges of understanding the different nomenclatures that exist.

We begin our chapter by raising a fundamental question as to what is meant by **disability** and **chronic health conditions** by considering medical and social models of

disability before considering the legal responses to disability generally and the lack of parity between physical and learning disabilities. In addressing the challenge of disability stigma, the chapter considers matters associated with disclosure (see also the chapter in this edition by Hoel, Lewis & Einarsdóttir on sexuality and bullying) and the steps employers and co-workers need to take to address this. We then turn to explore the limited empirical evidence for disability and bullying. The chapter then investigates the policy landscape of not only organisations, but also governments and policy makers to better understand how claims of bullying can occur. We close the chapter by considering the attendant organisational policy implications, not only through policies themselves, but also through the voice channels that allow the disabled and those who are chronically sick to have appropriate representation before ending with matters of importance to researchers and practitioners about researching people with disabilities and chronic sickness.

Main Text

Arriving at a definition of disability

Joe – a paramedic

“They call me ‘cloth-ears’ and tell me to ‘sit up and listen’ even though they know I have a hearing problem. Its demeaning and it upsets me, but I have learned to live with it and try and ignore it. But, it’s not what I expect from my work mates in the ambulance service”

Linda – a postal worker

“My line manager is fully aware of my mental-health status. I have had 2-3 episodes in the last 5 years which has caused me to relapse, but still he shows a lack of empathy to my situation. I have pointed out my legal rights to him but he chooses to ignore them. I have got to the point where I am now going above his head, but I worry I will be seen as a trouble maker. I know how he has made life difficult for other people by stopping their leave and changing their shifts. I simply can’t go on like this anymore as it’s making me more unwell”.

Examples such as Joe’s and Linda’s are common encounters to us as researchers of bullying in the UK and demonstrate some of the typical workplace issues people with a disability must confront. Even so, relatively little is known about the disabled worker experience, partly because they are under-represented in global labour markets (World Health Organisation & World Bank, 2011; Fevre, Robinson, Lewis & Jones, 2013), but also because of disclosure issues where many choose not to disclose their disability for fear of stigmatisation (Ellison, Russinova, MacDonald-Wilson, & Lyass, 2003). Within the broad acceptance on the importance of disability rights, there remains however, contentious issues about the term ‘disability’. The World Health Organisation, (2011, p.213) in their International Classification of Functioning, Disability and Health **defined disability** as “an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)”. However, as Wilson & Scior (2015) noted, this classification is wide ranging and does not differentiate between mental and physical health conditions.

Barnes (1992) argued that the term ‘disability’ is marginalized in today’s societies, often being described in negative and unpleasant terms. This led to an attempt for a clearer distinction between disability and **impairment** where disability is viewed by disabled people as discrimination, much like racism or sexism, because it disadvantages people with an impairment and excludes them from the mainstream. By contrast, impairment is an individual attribute with “any loss or abnormality of psychological, physiological or anatomical structure or function” (Barnes & Mercer, 1997, p.2).

This separation of disability from impairment is a very important one as it arose because of disabled people’s frustrations at being marginalised by mainstream researchers in a battle of social and medical models of disability. The **social model of disability** (Oliver, 1983) focuses on individual impairment of function, directing attention towards those environments that have cultures and attitudes that act as barriers to inclusive practices (Mawdsley & Lewis, 2017). In contrast, the **medical model of disability** is grounded in clinical diagnosis, which Brisenden (1986, p.173) argued is “destined to lead to a partial and inhibiting view of the disabled individual”. Goodley (2001, p.208) reasoned that a combination of focus upon impairment alongside the social model and wider disability movement “re-socialises impairment” largely because a focus on impairment alone is too closely aligned with the medical model.

Undeniably, in the modern era at least, it is the 1960s and 1970s that saw the first steps at raising awareness of disability rights largely from the civil rights movements in the USA (Winter, 2003), Australia (Soldatic & Chapman, 2010) UK (Barnes & Oliver, 1995), in the 1980s and 1990s in India (Mehrotra, 2011) and in the EU in 2000 (Whittle, 2002). For a comprehensive account of legislative adoptions on disability rights see Lawson & Gooding, (2005). **Legal responses to disability** arrived much later than protection for other discriminated groups but has nonetheless become widespread with USA (Americans with Disability Act, 1990); Australia (Disability Discrimination Act of Australia, 1992); UK Disability Discrimination Act (1995, 2005) and The Equality Act (2010); EU (Employment Equality Directive, 2000) and United Nations Convention on the Rights of Persons with Disabilities, 2008 being some examples. Yet, despite these legislations/conventions, concerns remain about negative attitudes to people with disabilities (Wilson and Scior, 2015). It is important at this juncture to recognise that the wider equalities movements have also faced something of a decelerating trajectory. The International Labour Organisation in their 2011 report “Equality at work: The continuing challenge”, cite the combined impact of the 2007-2008 global economic crisis, lack of political will and the ability of those who wish to discriminate to adapt and adjust to legal interventions which, all combine to provide structural discrimination.

Prior to the UK’s decision to leave the EU through the Brexit vote, ‘**hate crime**’ (a crime that is hostile on the grounds of race, religion, sexual orientation, disability or transgender identity) in England and Wales during 2015/16 had risen across most protected characteristic groups with disability hate crime standing at 6% - a significant 44% increase since 2014/15 (Corcoran & Smith, 2016). These figures demonstrate that, despite legislation arriving twenty years after sex and race protections to safeguard disabled people in the UK (disability protections passed into law in 1995 in the UK) and an enhanced Equality Act in 2010, the UK continues to struggle to see such legislative frameworks function as they should. Recent years have also seen the UK Government introduce a fee structure for employment rights issues to be heard at employment tribunals which has seen a dramatic fall in cases being submitted, further distancing the possibility of attaining justice (Pyper & McGuinness, 2015) (note there has been a recent trade union led challenge to the fee-based tribunal issue which is currently in appeal by the British Government).

Similar battles are reported elsewhere showing rising discrimination rates in the EU - up from 5% in 2005 to 6% in 2010 and to 7% in 2015 (First findings: Sixth European Working Conditions Survey, 2015) and skin colour/ethnicity and religious discrimination in Australia up 5% to 20% between 2015 and 2016 (Markus, 2016). As with many countries (see OECD, 2010; WHO-World Bank, 2011), Australia reported in 2015 that people with a disability were underemployed, more likely to be unemployed and spent longer time looking for work compared to non-disabled people (Australian Human Rights Commission, 2015) while in Britain, Adams & Oldfield (2012) reported how being out of work spiralled physical and mental ill-health for disabled people.

Physical, Learning and Chronic Ill-Health Impairment

Misconceptions about people with impairments continues to be a major barrier to employment, driving prejudicial views that people with disabilities are less productive than those without such impairments (WHO-World Bank, 2011) with some of the greatest prejudices reserved for those with **mental health conditions**. Evidence from Britain shows substantial differences in labour market activity and earnings for those with mental health problems (Jones, Latreille & Sloane, 2006; Hills et al., 2010). A fundamental challenge, at least in the UK, is despite legislation of 20 years or more, confusion exists with definitions of disability itself (Fevre, Foster, Jones & Wass, 2016). Fevre and colleagues argue that notwithstanding apparently straightforward legal definitions, employers, researchers of employment and disability, as well as legal experts and disabled people themselves, have significant difficulties recognising what is or isn't an impairment. The UK Equality Act 2010 recognises a disability as a "physical or mental condition which has a substantial and long-term impact on your ability to do normal day to day activities" (UK Equality and Human Rights Commission). This raises fundamental questions for those faced with dealing with disability. For example, does depression count as a mental condition? What does substantial and long-term mean? How do we assess impact and what is classed as 'normal'? Similar questions exist in Australian, (Handley, 2010), European (Waddington & Lawson, 2009), and North American (Burns & Gordon, 2010) definitions of disability discrimination and with courts interpretations of legislations.

A central challenge within disability discrimination is addressing the lack of parity between **physical** and **learning disabilities**. Physical disabilities have traditionally been addressed more effectively through access to work schemes (UK) where employers can apply for funding to adapt physical working conditions to address issues such as access, for example wheelchairs ramps (Adams & Oldfield, 2012). Physical disabilities have also had a longevity of support through advocates such as blind, deaf and hearing foundations/charities and from social movements (Barnartt, 2008) as well as supported employment, social enterprises and employability programmes (Decent work for persons with disabilities, ILO, 2015). In contrast, psychological and learning disabilities are a more recent disability focus gaining impetus in the new millennia (ILO, 2011). Gillberg and Soderstrom (2003) suggest that between 1-2.5% of the general population of the Western world have some form of learning disability embodied in a spectrum of conditions, while estimates from the WHO-World Bank (2011) showed 34% of respondents to a World Health Survey reported mild to extreme learning difficulties with a similar percentage having difficulties concentrating and remembering. In the UK in 2010/11, 6.6% of adults with learning disabilities were in paid work (Adams & Oldfield, 2012) but considerable variation exists in employment dependent upon the type of impairment an individual has. For example, some impairments such as locomotor or intellectual impairments were found to be more disadvantaging than others (Hills, et al., 2010).

Too often, psychological and learning difficulties are overlooked by organisations when considering disabilities (Waddington & Lawson, 2009) and training and support of supervisors and co-workers who engage daily with people with psychological/learning impairments is lacking because organisations fail to create the correct working environments (Robert & Harlan, 2006; Foster, 2007). Evidence from the UK showed employers often made assumptions about disability or underestimated disabled people's capabilities (Adams & Oldfield, 2012) even though researchers have shown learning disabilities do not impact on an individual's leadership potential (Luria, Kalish & Weinstein, 2013).

Disclosure, Reasonable Adjustments and Stigma

Reasonable adjustments in the UK (**reasonable accommodations** in the USA and EU) are often embedded in disability discrimination legislation forcing employers to make work accessible for disabled workers. Numerous researchers have commented upon the challenges of reasonable adjustments for disabled workers with a lack of awareness of rights from disabled people themselves (Adams & Oldfield, 2012), discriminatory attitudes from managers and employers (Foster, 2007; Fevre, Lewis, Robinson & Jones, 2012) and the potential of perceived unfairness by co-workers towards disabled people who have been given adjustments (Harlan & Robert, 1998; Colella, 2001; Adams & Oldfield, 2012). von Schrader, Malzer & Bruyère (2014) found that 25% of employees with impairments suffered long-term consequences for having disclosed their impairment. Researchers in Scotland using a CV (curriculum vitae) test found that applicants who disclosed a disability were half as likely to be called for interview compared to those with an otherwise identical CV (69% compared to 31%) (McRae & Laverty, 2006) and those with a disclosed Cerebral Palsy condition were 80% likely to be called for interview whereas a blind applicant was only called for interview in 20% of cases. Reverse findings were observed by Dalgin and Bellini (2008) who found psychiatric disclosed impairment suffering disproportionately to physical impairment in job application rating by employers.

With evidence such as these, **disclosure** choices around disability and chronic ill-health present some of the most fundamental challenges facing disabled workers. Disclosure has been often named as a major source of concern for those with impairments for not only discrimination, but also dismissal (Wilton, 2006). Wilton (2006) found that around 40% of employees with impairments did not disclose their conditions based on fears of hiring and retention. Also important is the notion of what Wilton called "loss or renegotiation of identity" (2006: 24) which can lead to further ill-health consequences. Of course, in most situations the disclosure decisions relate to **hidden or invisible impairments**, although as reported above, job applications from disabled employees cover the whole spectrum of impairments. The decision to disclose an impairment to either a current employer (for example after recent diagnosis of ill-health or a serious condition, or in the process of applying for promotion) has therefore far-reaching consequences for all parties.

In the UK, the Equality and Human Rights Commission (EHRC) states employers must not ask applicants about their health or impairments prior to being offered a job and to do so is illegal under the Equality Act 2010. The EHRC also advise that HR departments should not pass any monitoring forms that capture information on health and impairments to those making recruitment decisions. The UK's Advisory, Conciliation and Arbitration Service (Acas) make clear that there is no general duty upon an employee to disclose, but if they do so, interviewers must not ask further questions and furthermore, must take care not to be influenced by the information (Acas, 2016). UK legislation advises an employer can ask prospective employees if they require specific 'access requirements' which is not the same as asking an employee if they are disabled. In other countries, different conditions exist such as

in Canada where each Province has its own legislations, some of which require potential employees to disclose (see Wilton, 2006 for example).

von Schrader, Malzer & Bruyère (2014) argue that disclosure can work for an employee to ensure they receive their legally entitled appropriate workplace adjustments as well as assisting employers achieve any diversity and inclusion initiatives. The decision to disclose can also be a fundamental matter of life or death with some medical conditions requiring absolute clarity in the event of an occurrence (Vickers, 1997). Disclosure can also rally support for employees with impairments providing the work culture and co-worker support is robust (Baldrige & Viega, 2001; Kulkarni and Lengnick-Hall 2011). Wilton (2006) found that there were risks to non-disclosure because employees with impairments might be dismissed on performance grounds that might otherwise have been safeguarded had their conditions been disclosed. Similarly, an employer cannot normally be held liable for failing to make reasonable adjustments if they have not previously been made aware of the need for them (Acas, 2016).

The decision to disclose or not disclose is often arrived at in terms of cost/benefits with an individual's personal beliefs having to be considered alongside the prevailing workplace culture and their personal need for their impairment to be accommodated (Baldrige & Viega, 2001). Many employees with impairments perceive they will be isolated from their co-workers or be shown a lack of respect (von Schrader, Malzer & Bruyère (2014). von Schrader, Malzer & Bruyère (2014) found that a spectrum of complexities surrounded disclosure choices for people with impairments, particularly for those with non-obvious impairments and amongst those who had decided not to disclose, and that ultimately, employers must educate supervisors and co-workers on the challenge of bias stereotypes and resulting stigma, something we return to later, particularly as the relationship with supervisors was key to disclosure choices. In the context of bullying where so many incidences are perceived to be caused by poor management and/or supervisor practices (Hoel, Cooper & Farragher, 2001; Hoel, Glaso, Hetland, Cooper & Einarsen, 2010; Fevre, Lewis, Robinson & Jones, 2012), this is potentially even more problematic. It is perhaps also worth noting that although there are some similarities between sexuality and disability on matters of disclosure, impairments that are non-obvious can result in forced disclosure (Vickers, 1997) where an ill-health event such as a diabetic, asthma, epileptic or some other episode occurs in the workplace and non-disclosure is no longer possible.

Chronic ill-health

Throughout this chapter, we have interchanged 'disability' with 'impairment' with 'chronic ill-health/health conditions'. It is, perhaps, important to recognise that long-term health conditions are by their definition 'chronic' in nature. In the UK, disability and chronic ill-health are covered within the broad nomenclature of disability and under the same legislation (the same is broadly true in the USA, Australia and the EU). In the same way that disclosure choices are perhaps the most challenging for workers with hidden impairments, the same exists for chronic ill-health. Many working people will develop **chronic ill-health** through life changing illnesses such as Cancer, Diabetes and Leukaemia, but also through less life-threatening illnesses such as Irritable Bowel Syndrome or Arthritis. For workers who may have commenced their employment in an organisation in general good health, disclosure of such conditions can be very challenging and upsetting. Similarly, the difference between chronic ill-health and disability, although covered by the same piece of legislation, is often viewed differently by employees themselves with those in ill-health failing to recognise their entitlements as well as rejection of the disabled label (Adams & Oldfield, 2012). This requires significant work on the part of organisations and those that manage in them to ensure

all employees, regardless of impairment or health status, understand the conditions by which the legislation and attendant policies operate. As an illustration, the diagnosis of an illness such as Cancer entitles the worker to immediate protection as a chronic condition, whereas a less life-threatening condition would qualify after a period 12 months or more.

Disability and Bullying: The evidence thus far

Despite over 30 years of research into **workplace bullying**, evidence for those with disabilities and chronic ill-health remains relatively illusive. Nonetheless, the available data, however limited in volume, seems to warrant further investigation. Most of the research undertaken thus far comes from the UK where, in 2009, Fevre, Grainger & Brewer (2010) in the Fair Treatment at Work (FTAW) survey reported how British disabled employees in a nationally representative study were nearly twice as likely to report unfair treatment at work compared to other employees (19% compared to 13%) and with 7 out of 10 disabled people considering this to be discrimination. Disabled people were also over twice as likely to report experiencing bullying or harassment in the workplace (14% compared to 6%). In the 2005/2006 version of the FTAW survey, disabled women were four time more likely to be bullied than other employees (Grainger & Fitzner, 2007). Both the 2nd FTAW survey and the 2009/2010 Communities & Local Government Survey (2010), also in the UK, revealed promotion and recruitment decisions too often lie at the heart of disabled people's perceptions of discrimination.

Outside of the UK the limited available evidence points to similar findings such as in the USA (Robert & Harlan, 2006) with marginalisation, fictionalisation (false characterisations made by co-workers and supervisors) and harassment (both subtle and obvious) leading to stigma associations. The forms of harassment were typical of those reported in the bullying literature with jokes, teasing, rumour spreading, insensitivity and name calling (Robert & Harlan, 2006). Whereas these negative behaviours fit the generalised model of bullying and harassment, in the case of disabling impairments, they were deployed openly because of the impairment with the behaviours used directly in association. These correlations between **negative behaviours** and the protected characteristic status of the targeted person has also been reported in sexuality (Hoel, Lewis & Einarsdóttir, 2014; Einarsdóttir, Hoel, & Lewis, 2015) and ethnicity (Lewis & Gunn, 2007).

As with mainstream bullying, targeting people because of an impairment whether by supervisors, co-workers or clients of the organisation is ultimately the responsibility of the organisation's **leadership**, both legally and morally. As Robert & Harlan (2006; p. 614-615) commented, "organizations exercise power and control over internal operations that they either counter or encourage certain practices or environments" and "the proximate causes [of disability discrimination] are organizational mechanisms of resistance, particularly encouragement and tolerance". Roscigno, Lopez & Hodson (2009: p1561) suggest that without proper organisational guardians, bullying can function as a "managerial control tactic", particularly for those with low status, such as minorities who often occupy jobs with minimal levels of job security. As we point out below, disabled people, in Britain, Australia and in many other countries, often inhabit part-time jobs disproportionately to non-disabled people thus reducing their voice mechanisms and creating challenges for speaking up against bullying, particularly if they feel underemployed and seek additional employment hours.

One of the most noticeable pieces of evidence so far on bullying and impaired individuals comes from Fevre, Robinson, Lewis & Jones (2013) who showed that every item in their 21-item scale (British Workplace Behaviours Scale - BWBS) was statistically significant for people with impairments. Whilst the highest scoring item was "Being given an unmanageable workload or impossible deadlines" has been shown to be a prolific negative

behaviour in mainstream bullying too (see Einarsen, Hoel, Zapf & Cooper, 2011), it is worth recognising its prominence in the life of an impaired person. Disabilities and chronic health issues can often be debilitating, if not constantly, at different time periods meaning that **workloads and deadlines** may be harder to achieve during these times. Other items such as “having your opinions and views ignored” or “Your employer not following proper procedures” also chimed heavily with people with impairments because the deployment of reasonable adjustments by front-line supervisors/managers and the failure of the HR function to properly monitor, failed to ensure legal obligations were upheld on both sides (Fevre, Robinson, Lewis & Jones, 2013). Interestingly, their findings showed that “Your employer not following proper procedures” was not statistically significant for those with physical impairments, but was for psychological/learning disabilities and ‘other’ disabilities. This suggests that **invisible disabilities** are a source of major concern in their management in the employment relationship.

Also critical is that Fevre, Robinson, Lewis & Jones, (2013) found that people with impairments did not believe their targeting for these bullying behaviours was due to their disabilities, instead believing it was just how things were in the organisations they worked in. This sits well with Roscigno, Lopez & Hodson, (2009) who categorised organisations that allow bullying to function as ‘chaos’, because the organisation allows managers/supervisors to function with controls that are unchecked. In earlier work, Hodson, Lopez & Roscigno (2006: p408) found that in organisations without bullying, bureaucracy was used to facilitate work completion with flexibility “in consideration of the employees’ interests”. It is, perhaps, this failure of organisations to provide sufficient flexibility to meet the impaired person’s health needs that is one of the fundamental causes of bullying amongst this population. This is demonstrated by Fevre, Robinson, Lewis & Jones, (2013) and Foster (2007), who showed disabled people were disproportionately falling foul of draconian **sickness absence policy** where managers were hamstrung by invoking warnings for sickness absence, but who also failed to recognise the nature of the conditions that people with impairments or chronic health issues were working under. Adams & Oldfield (2012) reported how most disabled employees simply wanted small degrees of flexibility in how they worked – something organisations seem incapable of or unwilling to consider.

These challenges subsequently impact upon the ways in which bullying **policies** often require careful cross-referencing to other attendant policies such as sickness absence, grievance and so forth (Rayner & Lewis, 2011). These views of bullying and disability concur well with the findings from the 2nd FTAW survey (Fevre, Nichols, Prior, & Rutherford, 2009) where employees with disabilities were twice as likely to report problems with their employment rights.

The political landscape and the role of others

The utility and necessity of the social model of disability is evident from the preceding discussion. Disadvantage does not come from an individual’s impairment(s) *per se*, but rather from the attitudes of others and a failure of systems and institutions to adapt to those impairments (Barnes & Mercer, 2005). Tackling problems associated with the poor treatment of disability and chronic ill health in the workplace, therefore, necessitates identifying, challenging and seeking to change inhibiting practices and attitudes. Such problems and barriers, however, do not only exist at the workplace-level but are embedded in wider social, economic, legal and political contexts. These contexts can either facilitate, or more often constrain, workplace-level interventions. A discussion of work-related experiences of those with disabilities and/or chronic health problems should, therefore, account for the dynamic between employers, workers, legal systems, and government actions.

Government policy

In a statement made to the UK government in August 2017, Theresia Degener, the head of the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD), said that cuts to social policies made by the government had ‘led to a human catastrophe in your country, totally neglecting the vulnerable situation disabled people find themselves in’ (ITV news, 24 August 2017). That such a statement could be made in the 21st Century about a developed country such as the UK provides a stark reminder of the government-driven and legitimated barriers those with disabilities face daily.

The comment reiterated the findings of a 2016 report by the UNCRPD. Crucial to the current position of disabled people in the UK was the pursuit of austerity by successive Conservative-led/Conservative governments since 2010 – some consequences of this were set out early in the chapter. Purportedly grounded in a desire to emancipate people from benefit-dependency, and to improve access to work and therefore **labour market participation** for those with disabilities and chronic ill health, and to reduce the burden on tax payers, changes to welfare and support services and funding were made. In most instances, these took the form of changes, cuts and restrictions on the type and amount of benefits that could be claimed (Cross, 2013). What is particularly significant is that these changes were codified through legislation, for example in the Welfare Reform Act 2012. Legislating to make changes helps to entrench them and thus makes repealing them or changing course more difficult.

A notable focus in the government policy is a concern with **access to work** with little concern about the quality of that work. Labour market participation of disabled people has increased over the past few years (UK Office for National Statistics, 2017) but as the discussion in earlier sections of this chapter indicate, this has not necessarily translated into good quality work for those people. There has also been a great deal of controversy over the privatisation of capability assessments, used to assess work capability and the suitability (and legality) of the fitness for work tests used to assess whether individuals qualify for benefits (Griffiths & Patterson, 2014). The focus on access to employment for those with disabilities is not exclusive to the UK. Recent laws enacted in Germany (German Federal Participation Act 2016) and in India (Rights of Persons with Disabilities Act 2016) seek to facilitate the ‘self-determination’ of disabled people, and to develop a more inclusive society.

In Australia, the Department of Social Services of the federal Australian government has recently committed to a \$3 billion investment in Disability Employment Services (DES). DES are delivered by multiple providers and have a wide remit, focusing not just on access to employment, but also to the sustainability of employment by providing continued support once employment is obtained. Support is provided in the form of training and advice for job seekers, as well as for employers who seek assistance in interpreting the relevant legislation and in making modifications. Employment is also facilitated through **Australian Disability Enterprises** where those with disabilities find employment in a wide range of industries. Despite the relatively high level of support provided and encouraging success rates (Department for Social Services, 2014), problems persist. The Australian Human Rights Commission reported that the highest percentage of enquiries they received related to disability discrimination (18%) (AHRC, n.d.).

The way in which interventions are justified and discussed by those responsible for their creation and implementation is arguably a component of understanding the experience of those with disabilities and/or chronic health problems since these may lead (or follow) public opinion and perceptions.

Politics and politicians

From the podium of a campaign rally in late 2015, the then Republican presidential candidate, Donald Trump, physically and verbally mocked a journalist with a congenital joint condition. Trump was criticised for this in several media outlets. His response was simply that that was not what he was doing. His campaign continued and he is now President of the United States of America. In September 2017, rumours emerged of him mocking the disabled Senator John McCain. In both circumstances, it appears that the behaviour was a reaction to the people in question, questioning or failing to comply with what Donald Trump wanted. In the UK, politicians also fair badly. In a 2015 House of Commons speech, the then Work and Pensions Secretary Ian Duncan Smith, the minister responsible for making cuts to welfare, referred to those without disabilities as 'normal'. This was met with outrage from trade unions, fellow MPs and disability groups but did not appear to damage Duncan Smith's career.

These are not necessarily isolated examples in politics across the world. Vellani (2015) argues that **political discourse** around disability is often patronising; while Hughes (2015) argues that the pursuit of austerity and neoliberalism have led to a 'demonisation of disabled people' by positioning them as 'cunning and fraudulent' in respect of the provision and claiming of disability-related benefits. This kind of language and treatment of disability and illness echoes the workplace experience of those in research conducted by Coleman, Sykes and Groom (2013). Of course, many criticisms can be levelled at politicians and party politics are not the only reference point for behaviour and attitudes around disability and illness, the media, for example, also play a fundamental role (e.g. Kamenetsky, Dimakos, Aslemand, Saleh & Ali-Mohammed, 2016). Nevertheless, as public figures and bodies, politicians and governments can, and should, act to model good behaviour.

Greater diversity in the composition of governments may also lead to better outcomes for those living with disabilities and/or chronic health problems, both in terms of representation of interests, and providing role models and public figures that can help to challenge perceptions about the capabilities of those with impairments (Ozarow, 2015). The UK 2017 general election saw the highest number of disabled MPs being elected to the UK Parliament in history. This improvement, however, translates into just five MPs, or 1% of all MPs. Estimates suggest that 18% of the working age population alone reported a disability (2015/16) (Department for Work and Pensions, 2017) meaning the 1% presence among MPs may represent progress, but it fails to adequately reflect the prevalence of disability in wider populations. Ozarow (2015) argues that **structural conditions** persist that prevent the ability of disabled candidates to come forward and succeed. Steps are, nevertheless, being made in the right direction but there is still a long way to go. Notably, Jared O'Mara, a newly elected Labour MP with cerebral palsy has been experiencing problems related to access in the Houses of Parliament, e.g. inability to get a seat in busy sessions and the use of an unsuitable lock on his office door, bringing the need to make reasonable adjustments to enable people to do their jobs to the fore.

Law and the role of tribunals and courts

The role of **law** in grounding and potentially shaping the workplace experiences of those with disabilities and/or chronic health problems is significant, since it provides the foundations on which many aspects of employment relations should be conducted. Through processes of judicial review and the evaluation of government exercise of power, courts also help to play an important role in democratic societies (see for example Gardbaum, 2014).

As indicated above, law dictating and shaping the experience of people with disabilities/chronic health problems extends beyond discrimination and employment law. However, here the focus will be on anti-discrimination legislation and employment law since these provide rights and impact the mechanisms available for pursuing and enforcing those rights.

Across EU member states, disability discrimination legislation primarily comes from Directives (e.g. Employment Equality Framework Directive 2000/78/EC) and though there may be some variance in implementation and impact across Member States (see Moody et al., 2017 in the context of disability), the directive and related decisions of the European Court of Justice (ECJ) dictate much about the scope of protection. The scope of who is classed as disabled under the law, for example, has been led by the ECJ e.g. the 2015 decision that obesity itself does not qualify (*Kaltoft v Municipality of Billund* (2015) Case C-354/13).

Courts have also been instrumental in taking steps to recognise the role **carers** play in supporting equality for disabled people. In *Coleman v Attridge Law* (2008) C-303/06, the ECJ ruled that direct discrimination and harassment also applied to those who were related to or connected to disabled people and who suffered detriment because of that, not just those who are themselves disabled. In the *Coleman* case Mrs Coleman claimed she had had to resign from her job as a result of harassment related to her caring responsibilities for her disabled son. A 2015 ECJ ruling extended protection to also include indirect discrimination by association (*CHEZ Razpredelenie Bulgaria* [2015] EUECJ C-83/14). This protection from ‘**associative discrimination**’ was enshrined in the UK Equality Act 2010. The rights, however, are not fully equivalent to those with a qualifying disability. The UK Court of Appeal in *Hainsworth v Ministry of Defence* [2014] EWCA Civ 763 found there was no duty to make reasonable adjustments for associative discrimination and the duty is therefore limited to employees, prospective employees and trainees. Due to its basis in the 2000 Directive, associative discrimination thus applies across EU Member States; it is also recognised elsewhere, for example in the USA and Australia.

Under EU law, disability protection applies across the employment cycle. This broad scope is important since it concerns not only access to employment, e.g. recruitment, but also progression in employment (e.g. promotion), experiences whilst employment (e.g. right to be treated with dignity), and the end of employment (e.g. termination). Although the scope is similar in providing protection from recruitment, the Americans with Disabilities Act 1990 is more restrictive, applying only to organisations employing 15 or more employees. This means that rights are limited according to employer size. This raises interesting questions about the underlying rationale for anti-discrimination legislation and the extent to which protection grounded in civil rights and respect for dignity (Fredman, 2011), provides protection that is contingent, rather than universal. An element of contingency in employment protections is, however, not restricted to the US and employer size – it is also arguably inherent in the notion of *reasonable* adjustments (or accommodations).

Duties and problems associated with reasonable adjustments have been considered above, and, in practice, much will depend on the circumstances of the case. Understanding what counts as a reasonable adjustment can be difficult and relying on judicial determination on case-by-case is not a realistic solution. Guidance has, however, been developed at the national level to assist with this, for example by Acas in the UK, the Equal Employment Opportunity Commission in the USA and joint guidance from the Article 33 Convention Coalition Monitoring Group, the Office of the Ombudsman and the Human Rights Commission in New Zealand.

In addition to the substance of the law, understanding the extent to which individuals seeking to rely on the law can do so is of great relevance to debates on employment barriers

and tackling harassment and bullying around disability. This operates at both the workplace-level, for example through the existence and accessibility of grievance procedures, and beyond this (likely when an employment relationship has ended), through the pursuit of a legal claim. Several factors influence the extent to which people with disabilities may be able to access *justice*, including knowledge of rights, access to advice, support through the complaint process and resources (see Blanck and Flynn, 2017). Other potential barriers have been noted above, e.g. organisational culture and management attitude. While the courts have, and continue to, play an important role in developing standards and protections for better workplace treatment of those with disabilities and chronic health problems, pursuing a legal claim is often not desirable, or feasible, and therefore resolution at the workplace-level should be encouraged where appropriate.

The evidence presented thus far indicates that the presence of anti-discrimination law prohibiting differential treatment and protection from harassment has not served to eradicate barriers and prejudice against those with disabilities and/or chronic health problems. Relative to anti-discrimination law related to sex and race, protection against disability discrimination is relatively new, with the former emerging in the 1960s-70s and the latter, in most cases, not until the 1990s. Even after decades of legislation and associated litigation, barriers to employment and harassment on the grounds of sex, gender and race remain prevalent so the persistence of issues around disability is no surprise. While protection for certain groups through anti-discrimination legislation sends an important normative message, law alone has its limitations (for example see Dickens, 2013). These limitations mean that alternative routes to enforcement, regulation and engendering change are needed.

Trade unions

The history of the involvement of trade unions with the disability movement is mixed (see Richards and Sang (2016) for an overview). There are, however, some successful examples of trade union programmes across the UK, particularly because of the refocusing on learning as a potential route to modernisation (Richards & Sang, 2016). Richards and Sang (2016) analysed the impact of a union-led initiative designed to provide support for, and raise awareness of, employees with *neurological impairments* working in the UK rail/transport industry. This had had some positive impact, for example through the utilisation of neurodiversity champions and the influence afforded to these by a presence in disability/equality forums. It had also led to neurodiverse employees feeling more supported by their union. The introduction of disability representatives and/or equality representatives has also had some success in encouraging employers to conduct audits and reviews of their policies and practices, but this has not necessarily translated into a willingness to make reasonable adjustments (Bacon & Hoque, 2015). Scope for success of representatives may also be limited by a lack of time, specialism and resources available to them to pursue disability issues (Bacon & Hoque, 2015; Bennett, 2010; Moore & Wright, 2012).

With the increase of individual employment rights and the decline of collectivism, trade unions have increasingly become an important source of legal advice and source of support using individual procedures, e.g. disciplinary and grievance complaints (Colling, 2006). The existence of specialist reps, forums, and indeed of trade union presence, will, however, vary according to organisational size and sector, and there is, therefore, some limitation to the type of employees who may be able to benefit from these. Indeed, where disabled workers are disproportionately represented in low paid and precarious work, access to this sort of support may be lacking. Despite trends towards declining trade union power, some, such as Dickens (1999) argue that they play an important role in the pursuit of a balanced equality agenda, helping to mitigate and negotiate employer and state interventions,

and to challenge the dominance of business case arguments in diversity management. Richards and Sang (2016) also argue that trade unions play an important role in the recognition of **disability as a collective issue** and in countering the individualism of much of the support offered to disabled people from disability advocacy organisations.

Stigma and Disability

Just as insight into a way forward for understanding the experience of those with disabilities and/or chronic illnesses may be drawn from the literature – particularly around stereotypes and stigma – on sexual orientation and bullying; research and literature on the workplace experiences of disabled people from other fields, for example psychiatry and social psychology in relation to **mental illness**, can provide significant insights. Such research may be particularly useful for understanding how pre-existing conditions may be an antecedent to bullying. Behaviour experienced by individuals because of their condition and stigma attached to it may be labelled as bullying, but beyond limited reference in Russinova, Griffin, Bloch, Wewiorski and Rosoklija (2011), there has been little consideration of how these experiences may be accommodated or understood within the bullying literature. When **prejudice** and poor understanding of disability and illness are a core source of the mistreatment of people with impairments (Coleman, Sykes & Groom, 2013), understanding and exploring the source and form stigma and stereotypes take is arguably a necessary part of accurately accessing and representing the problems and experiences of those bullied and/or disadvantaged because of them, and ultimately, therefore, of evaluating interventions to redress this problem.

Organisational implications

The above discussion leads to several organisational implications. To facilitate active participation and representation of those with disabilities and/or chronic health problems in safe and respectful workplaces, many points need to be acknowledged and addressed.

(1) Reasonable adjustments are necessary but not sufficient. Ignoring differences and the need to make adaptations to working practices and environments is both unhelpful and potentially unlawful. Employers need to be aware of their duties under the law, and where a disability and/or chronic illness is disclosed, be open and willing to discuss with the individual in question what adjustments could be made. Employers should then decide whether or not those adjustments are reasonable. Where employers are uncertain they should refer to guidance and/or consult with specialists, e.g. employment lawyers. Senior management and leadership buy-in is essential, and employers should seek to be proactive and train line managers and/or HR personnel in dealing with disabilities. There are obviously cost implications involved, as well as capacity and capability issues, especially where resources are limited and/or there is no specific HR function (e.g. in many small or medium sized enterprises - SMEs) but employers should, at the very least, seek to engage with free guidance and support that is available (e.g. via Acas).

Taking a more **proactive approach**, for example gaining recognition from Jobcentre Plus (the UK government agency linking the unemployed to obtaining work) as a “two ticks” employer and committing to embedding positive action towards disability within the organisation, could also be an important key stone for establishing a culture that is encouraging and supportive of disability and/or illness.

Since bullying behaviours are not exclusively related to reasonable adjustments, creating a **culture** that establishes what is, and is not, acceptable behaviour, for example through the introduction, implementation and enforcement of dignity at work policies, is

essential. Even though adjustments may need to be made on an individual basis, the social model of disability recognises that disability is not an issue that is isolated to a specific individual but that it is a shared and socially-constructed one, meaning interventions to address the bullying of those with disabilities and/or chronic health problems requires an adjustment in attitudes and understandings, as well as to the organisation of work. Seeking to create an environment that is open and understanding to different disabilities and health-related problems as standard can potentially help to shift the responsibility for challenging disadvantage and mistreatment away from the disabled/ill individuals themselves as it takes the onus away from them to pursue change through individual complaints procedures. Except where reasonable adjustments are required, adopting this approach may also help to reduce the need for individuals to disclose a disability and/or illness to personally challenge stereotypes or perceptions about this.

(2) Complexity is not an excuse for inaction. Again, there is a need for employers to seek to educate themselves to take steps to rectify existing problems, and/or to put steps in place to stop them arising or escalating. Making adjustments, for example to sickness and attendance policies can be difficult, especially where consistency and transparency are important for ensuring procedural justice (e.g. see McCalla (2015) in the context of bullying and heterosexism). Research into **diversity management** (Foster & Harris, 2005) and **conflict management** (Saundry, Jones & Wibberley, 2015) has also shown that managers are wary of informality and differential treatment where policies exist, in case straying from the structure provided exposes them to potential criticism or liability. Nevertheless, incorporating scope for flexibility within the policies and procedures and anticipating what that flexibility may be, may help to balance the need for variance with that for consistency. Developing competency and confidence in line managers to navigate this complexity is crucial, especially as failure to do this may serve to limit scope for support and restrict feelings of representation in an organisation (Richards & Sang, 2016). Changing attitudes and cultures and making reasonable adjustments can be a highly complex process, requiring the balancing and weighing up of multiple competing factors, e.g. productivity and achieving efficiencies through the imposition of targets or restructuring of work that disadvantages or penalises certain disabilities (Mawdsley & Lewis, 2017) or permitting stereotype-based **humour** or disability-related “banter” if it appears to improve morale overall, or is led by a high earner. The last example is not exclusive to disability-related bullying and discrimination but is rather a problem underpinning bullying, harassment and discrimination more broadly (see for example Harrington, Rayner & Warren, 2012); this issue also leads to the next.

(3) Protection from discrimination, bullying and harassment should not be excused or legitimated in the name of organisational performance. This may manifest in the form of individual victimisation or may be the result of oppressive work practices (Hoel & Beale, 2006). In either case, however, employers should not facilitate (or actively encourage) the use of direct or indirect discriminatory practices, and/or the use of language and **behaviour that is derogatory, insulting or humiliating**, even where these, on balance, appear to result in higher performance and productivity. The dignity of individuals should be protected and prioritised and this (along with the need to overcome historical disadvantage), lies at the heart of anti-discrimination legislation (see Fredman, 2011 for a discussion on the development of equality law). Discourses around disability and illness in a workplace context may also go beyond those concerned with equality and diversity, they also appear to be increasingly associated with wellbeing (e.g. Spiegel, De Bel & Steverink, 2016). This opens up potential for further cooperation and collaborative action across functions, for example HR, equality teams and occupational health.

(4) Representation and voice is important. Tackling problems at work associated with disability and/or chronic health problems requires both individual and collective actions. Adjustments may need to be made on an individual basis but changes to attitudes, institutions and structures need to be done on a collective basis. An important component of this is providing appropriate voice, representation and participation mechanisms (Fevre et al, 2016). A few examples of how this may be done include the creation of equality and diversity forums, disability support networks the introduction of disability representatives. However, for these to be meaningful it is important they are given sufficient resources and influence (see for example Bacon and Hoque, 2015). Bipartite social dialogue between employers and trade unions/employee representatives can potentially play an important role in setting and enforcing standards tackling workplace harassment, even in the face of increasingly individualised employment relations (Deakin, 2017). Individual job seekers and workers should also have access to affordable and accessible **advice**, support, and where necessary representation. Possible sources for these include employers, trade unions, government schemes, and charities and NGOs but a national commitment to improving the position and experiences of those with disabilities and closing the disability employment gap should include government funded projects and services.

Researching disability and bullying

These debates around the labelling of disability, impairment, medical and social models, politics, trade unions and stigma are important fundamentals for bullying researchers to grasp. This is not least because of the epistemological (and political) assumptions researchers bring to any investigation. Bullying researchers are principally drawn from psychology, sociology, industrial relations, economics and health professions backgrounds each with its own traditions and nomenclatures. Bullying research has also suffered from measurement problems (Nielsen, Mathiessen & Einarsen, 2010; Fevre, Robinson, Jones & Lewis, 2010) and claims of methodological weakness in the rush for phenomenological discussion (Keashly & Harvey, 2005). Similarly, both bullying and disability researchers have been concerned with social desirability bias (Fox & Stallworth, 2005; Lewis, Hoel & Einarsdóttir, 2013; Wilson & Scior, 2015) and the subsequent dangers of generalisation that result. With a deficiency of empiricism in research on disability and bullying these are critically important foundational issues.

Research has shown that people's attitudes to disabilities varies, dependent upon the disability in question (Gray, Cripps & Johal, 2009). Fevre, Lewis, Robinson & Jones (2012) showed fundamental differences in the exposure to workplace ill-treatment for people with physical versus psychological/learning disabilities. This suggests it is critical that researchers capture the multiple forms that disabilities and chronic health conditions can take in their research designs. Simply asking single questions on disability is unlikely to provide insight into the rich variations that exist within the disabled category. Similarly, researchers need to take considerable care with **estimating disabled populations** because of disclosure concerns that disabled people have. As such, building in safeguards and assurances when capturing responses from disabled people who might have encountered bullying and discrimination is paramount (Lewis, Hoel and Einarsdóttir, 2013) (see also the chapter in this edition by Hoel, Lewis and Einarsdóttir). Furthermore, relying on secondary data from self-reporting measures on disability must be taken with extreme caution given the inaccuracies associated with self-disclosure on disability (How fair is Britain?, 2010).

Researchers must also recognise the **intersectionality** of other demographic categories with disability. Obvious associations exist between specific chronic ill-health conditions, disabilities and older aged workers, but there is also specific sexuality, ethnic and religious

populations who suffer poorer rates of ill-health, higher rates of disability and inferior mental health (How fair is Britain? 2010; Hoel, Lewis & Einarsdóttir, 2014). It has also been shown that some of these populations have greater difficulties communicating their health conditions and health needs making engagement with them fraught with difficulties for researchers. In many countries, disabled people are also more likely to work part-time (How fair is Britain? 2010; Willing to Work: National Inquiry into Employment Discrimination Against Older Australians and Australians with a Disability, 2016; *Decent work for persons with disabilities: promoting rights in the global development agenda*, 2015) and with growing patterns of insecure and flexible employment, this employment pattern is likely to grow further. Whether this is a bad thing is of course a moot point with part-time work for some disabled people fitting their health condition or chosen working patterns. Robert & Harlon's (2006) early observations on the impact of **public sector financial constraints** on people with impairments, more latterly confirmed by Mawdsley & Lewis, (2017), showed that managerial expectations of higher productivity outcomes directly impacts on disabled and chronically sick people. The expectations placed on public sector workers to do more with less to appease political leaders, which Robert & Harlon (2006: p.619) called "the ideology of scarcity", forces competition for resources and job security which, because of their over representation in part-time employment, creates specific challenges for disabled employees.

This combination of over representation in part-time work and a competitive drive to survive in public sector work, a traditional domain of disabled employees in the UK (Hirst, Thornton & Dearey, 2004) presents challenges to researchers, firstly to ensure they sample appropriately, but secondly to ensure they understand fully how the behaviours encountered impact into bullying on people with impairments in ways that may be different from non-disabled people. Thirdly, the **policy landscape** around sickness absence monitoring, performance management and bullying/harassment policy needs to be better understood. As such, researchers need to have not only empathy with the disabled populations they research, but where possible close affinity with them (Lewis, Hoel and Einarsdóttir, 2013) to understand their lived experiences.

It is also clear that researchers must look closely at the reasons why disabled people feel ill-treated at work. With numerous sources (Fevre, Grainger & Brewer, 2010: Communities & Local Government Survey, 2010: Fevre, Lewis, Robinson & Jones, 2012; Hoel, Lewis & Einarsdóttir, 2014) showing disabled people at greater risk of bullying and ill-treatment, it is essential that researchers look closely at; a) promotion and recruitment decisions and why these may be perceived as discrimination (Fevre, Grainger & Brewer, 2010); b) managerial decisions about reasonable adjustments (Fevre, Robinson, Lewis & Jones, 2013) and; c) disabled people's concerns over sick leave, pay, holidays, rest breaks and complaints/grievance procedures (Fevre, Nichols, Prior, & Rutherford, 2009). These are a solid platform upon which bullying researchers might build.

Conclusion

Despite decades of interventions, both legal and social, to address discrimination against minorities, disability discrimination is a relative latecomer. Largely neglected by mainstream bullying researchers there is an undisputable need to capture data on the workplace experiences of those with impairments and chronic health issues. For this to occur, researchers need to fully understand the complexities of law, policy and theoretical foundations of disability before embarking on research capture. Further complexities exist in designing effective research, particularly that can gather the composite spectrum of disability impairments and how these intersect with behaviours and actions of individuals and organisations that employ them that potentially lead to claims of bullying. This requires

significant sensitivity on the part of both researchers and organisations so that this may be conceived of as a shared problem requiring multiple layers of intervention. Research should concentrate not just on prevalence but on understanding the qualitative and lived experiences of people living impaired lives. As research on bullying and disability evolves, insight from the experiences of other groups (particularly LGBs – see the chapter in this edition) and from other fields (e.g. sociology and health) can be extremely valuable.

As has been reported on numerous occasions by researchers of workplace bullying, this begins and ends with strategic support from organisation leaders, without which, nothing changes. Additionally, there is a significant interplay with support functions such as occupational health, counselling and HR to ensure managers/supervisors and the wider workforce are abundantly clear of the legal and moral implications of their actions. This, ultimately, requires a cooperative and collaborative approach involving trade unions, employers and the whole workforce. With public opinion sometimes oscillating as result of political rhetoric towards disabled people, much more needs to be done to recognise their valuable contributions, both current and potential. It is incumbent upon all to ensure workers with impairments and chronic ill-health are neither mocked nor made subject of punitive sanction through unfair policies or practices.

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