Black Lives Matter – Special Edition CRSW 10 years on.

Abstract

This paper critically examines the impact of Health and Social Care provision on separated categories of race, disability and neurodivergence. It deconstructs the racist impacts of the neoliberal individual budgets' agenda as experienced by a Black African young person with intellectual disabilities and autism, living as a 2nd generation migrant in the United Kingdom, (UK). This paper highlights intersectional methodological and practice implications for health and social care provision within England and Wales.

The erasure of intersectional race, intellectual disability and disability neurodivergent identities in UK health and social care policies and practice procedures results in the invisibility, misrecognition, and consequential misdiagnosis of the intersectional complexities of the needs and entitlements of Black young people. The convergence of racist, disablist, elitist neoliberal agendas is identified as leading to increased risks of incarceration for young black people with intellectual disabilities and autism. The specificity of the individual needs of young black people with intellectual disabilities and autism demand anti-racist approaches that confront the assumption that Black African families in the United Kingdom, "look after their own" and require minimum social care involvement.

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The term ‘intellectual disability’ is used in the United Kingdom interchangeably with ‘learning disability’. Historically various terms which are now considered pejorative have been used such as mental handicap, retardation, mental sub-normality; mentally or morally defective as well as feebleminded. These terms reveal the othering and discrimination that people with intellectual disabilities have been subjected to over the years. The current terminology of intellectual disability may appear to be less discriminatory however it is still based on a discourse that devalues and discriminates against differences based on intellectual functioning. The ICD-11, (2019) uses the term ‘Disorders of Intellectual Development’ to align with the World Health Organisation (WHO), Family of International Classifications that distinguishes health conditions (ICD) from their consequences (International Classification of Functioning, ICF). The label of a medical disorder always carries the connotations that the impact of the condition is negative, disadvantageous and therefore requires interventions by professionals and concerned members of the society, (Spitzer and Endicott, 2018).

The World Health Organisation, (2022) explains that an “Intellectual disability means a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development.” There is an emphasis on the assessment of intellectual functioning using normed, standardized tests. The difficulty with these tests is that they are geared towards neurotypical people with a Eurocentric background. In the context of the United Kingdom (UK) where there are diverse global backgrounds, assessments for intellectual disability may be flawed. The unique capabilities and giftings of individuals may be overlooked whilst assessed ‘deficits’ are highlighted and used to deny people opportunities to excel in their areas of strength. There is a need to recognise neurodiversity as a fact of life, whereby all members of our society exist on a nuanced spectrum between neurotypical and neurodivergent manifestations, constituting "a natural and valuable form of human diversity" (Morrison, 2019).

“One way to understand neurodiversity is to think in terms of human operating systems instead of diagnostic labels like *Autism* and Attention-deficit hyperactivity disorder (ADHD). …………Just because a computer is not running on Windows doesn’t mean that it’s broken. Not all features of atypical human operating systems are bugs. By autistic standards the *neurotypical* brain is easily distractible, is obsessively social, and suffers from a deficit of attention to detail and routine. Thus, people on the spectrum experience the neurotypical world as relentlessly unpredictable and chaotic, perpetually turned up too loud, and full of people who have little respect for personal space, (Silberman, 2015:471).” There is a history of neurotypical people labelling the actions of neurodivergent people with negative stereotypes such as they lack humour or creative imagination, (Silberman, 2015). Discrimination against neurodivergent people has a long history indeed which labels people as "pitiful" and "abnormal”. There is an urgent need for people with intellectual disabilities and neurodivergence to engage in ‘creative resistance’ which includes enjoying their difference and actively keeping their differences rather than being moulded into neurotypical representations, (Afuape, 2011). This paper considers the intersectional experiences of a young neurodivergent person in the United Kingdom.

Case Study Background

Ayobami is an 18-year-old young person from a Black African background. He has a diagnosis of an Intellectual Disability and an Autism Spectrum Condition, (ASC). Ayobami has an exceptional long-term memory, is good at pattern recognition, puzzles, athletics and is fun to be around. Ayobami lives in a City in the United Kingdom with his parents who are 1st generation migrants. He attends a Special School in his local area. Ayobami uses a picture exchange system of communication at school. He also uses some phrases, gestures and behaviour to communicate. When Ayobami was 16 years old his parents were awarded an individual budget by the local authority to purchase support for Ayobami when required. They have been managing this budget with yearly reviews from the local authority. Ayobami has previously been under the care of a Consultant Child and Adolescent Psychiatrist. He is prescribed 2mg of Risperidone by the Psychiatrist to manage his behaviour.

Ayobami's mother Rachel has shared with the Psychiatrist that he recently threw a kettle filled with boiling water onto his father's back. This left his father James with significant injuries thereby reducing the support available for Ayobami at home. Ayobami continues to attend his special school Monday to Fridays where he receives Positive Behavioural Support. Ayobami has also been referred to the Community Intellectual Disability Team for a Communication Assessment, Sensory Integration Assessment and Functional Behaviour Assessment. They have a waiting list of at least 9 months. Ayobami continues to display complex, distressed behaviours at home and at school which include kicking, hitting, throwing things, running away, making loud noises and screaming. His parents approach a local organisation which supports people with Intellectual Disabilities and related Physical Health issues. They request for Ayobami to be supported by this organisation twice a week to access the local community. This is so that Ayobami is occupied with activities he likes and also to provide respite for the family. This support is to be funded through his individual budget. The organisation plan to take Ayobami swimming every Friday and to go for long walks or community activities on Sundays. The first Friday Ayobami is supported to the local swimming baths by his new support team, he hits a young child. The Duty social worker in the Community Team for People with Intellectual Disabilities received the following report from the police;

"Ayobami Adenike an 18-year-old male has been arrested for the severe assault of a minor at the local swimming baths. He had attended the swimming baths as part of a group of 10 disabled people who were being supported by two members of staff on a swimming activity. CCTV shows Ayobami running into the changing rooms, and a few minutes later a father emerges from the changing rooms calling for help. The father reports that Ayobami ran into the changing area and without provocation kicked his 9-year-old son in the head leading to the child falling and losing consciousness."

This case study reveals the devastating impact of overlooking the intersectional experiences of a racialised young person with an intellectual disability and autism. People are often disadvantaged by multiple sources of oppression based on markers such as race, culture, gender, identity, disability and religion, (Cho, Crenshaw &

McCall, 2013). "Intersectionality successfully exposes socially constructed borders of experience and goes on to detail the destructive negative consequences of separated out categories, (Nayak, 2015:90)." The Equality Act, (2010) and guidance from Public Health England (2020), places a duty on health and social care services to make reasonable adjustments to ensure that their services are accessible to people with intellectual disabilities. This also includes making adjustments to environments so that they serve the needs of disabled people. Furthermore, this duty it to be anticipatory, meaning services cannot be reactionary, but must engage in forward planning to ensure that the needs of disabled people are met as and when service interventions are required. According to data released by NHS Digital, (2020), there were at least 2,170 people with a learning disability and/or autism in England, locked away in hospital units where restrictive inventions were being increasingly used. The average total length of stay in these in-patient units is estimated at 5.5 years, (NHS Digital, 2020). These figures suggest the government's transforming care agenda of increasing the capacity of community services, such that people with intellectual disabilities and autism are not being subjected to increased oppression has not been effective. In instances where a person with intellectual disabilities and autism is admitted into a hospital setting, their intersectional experience of oppression is enhanced. The Department of Health, (2015), highlights the risk of blanket restrictions often found within hospital units, whereby specific rules or policies are applied routinely to everyone within the service, often without a suitable justification for their application.

Intersectionality is an anti-border theory and method that enables us to see the impact of socially constructed borders of experience, (Nayak, 2015). The following questions pivot on socially constructed borders and the possible answers to the questions reveal how racism is re-produced through bordered attitudes:

1. What do people assume about black Africans in the UK?
2. What do people assume about immigrants and people whose accent isn't typical of the regions of the UK?

As the case study demonstrates, the consequences of socially constructed borders of thinking, attitude and behaviour had far-reaching implications for Ayobami. In terms of Ayobami’s needs it is evident that social borders were subtly in play regarding his health and social care support. Just as geographical borders vary from discreet signs announcing the existence of a boundary, to the intricacies of customs inspections and military checkpoints, social borders vary in degree of definition from minimal acknowledgment of social similarity to public and formal proclamation of difference, (Ross, Aggarwal, Bessac, Blacking, Brentjes, Casagrande, Casagrande, Cohen, Douglass, Gohring, Gold, Goldberg-Mulkiewicz, Hannerz, King, Klejn, McCormack, McGee, Swiderski, Von Mering, & Ward, 1975). “When individuals who share a status feel that certain things are expected of them, or denied them collectively, on the basis of this common status, the border becomes one degree more sharply defined. In this sense, the weight of the majority perspective and experience re-produce social borders patrolled by shared norms. Authoritative, statements such as “we feel”, "our" problem, or "our" place in society, demarcate the ‘deviant’ and legitimates the representation of the deviant as threating because they ‘make us look bad’, (Ross et al, 1975:54).” The manoeuvres to regulate the threatening deviancy of first-generation migrants with a son who is represented as aggressive is precisely an enforcement of social borders with the ‘sly civility’ of good intentions, managing a difficult situation for the greater good of others and disavowal of intense uncomfortableness, (Bhabha, 1994:93). This may lead minoritised parents to attempt the management of their neurodivergent children without drawing undue attention to the family.

The erasure of intersectional race, intellectual and neurodivergent identities in UK health and social care policies leads to the misrecognition and misdiagnosis of needs. Assumptions that the needs of a racialised and minoritised person with intellectual disabilities are no different from the needs of dominant groups in society leads to a skewed view of equality. Although it is acknowledged that race is a social construct with no biological basis, the impact of racism on minority racialised groups can be devastating, (Ellis, 2021; Wesp, Ruiz, Weitzel, Kako and Mkandawire-Valhmu, 2018). Afuape, (2011), notes for instance that racist representations of young black men as violent leads to acceptance of their exclusion from some parts of our communities. Welsing, (1991:2), defines racism as, “The local and global power system structured and maintained by persons who classify themselves as white, whether consciously or sub-consciously determined; this system consists of patterns of perception, logic, symbol formation, thought, speech action and emotional response.” These patterns that perpetuate the marginalisation of non-white people may not be discernible to the person with Intellectual Disabilities however they cause their environments to become more disabling and oppressive. Ellis, (2021), suggests that we hold race conversations within our various contexts where we begin to develop an understanding of the dynamics of racism in our history and present, exploring our connection to racism personally, generationally and genetically. It is evident that for most people discussions about racism are triggering to the nervous system as they may be perceived as threatening. Where health and social care services do not adequately meet the needs of racialised people, there may be arguments that these failures have no connection to racism. However, it is worth noting that our identities are frequently interwoven with the race construct such that it becomes difficult to isolate those parts of ourselves that continue to cause harm as part of the system of racism, (Ellis, 2021).

Health and Social care workers need to develop cultural humility which is “a lifelong commitment to self-evaluation and critique, to redressing power imbalances . . . and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations” (Greene-Moton & Minkler, 2020:123). Culturally congruent services are tailored to fit in with the recipient’s cultural values, beliefs, traditions, practices, and lifestyle (Jeffreys, 2010). Wesp, et al, (2018), note that discrimination may occur when service providers overlook the specific needs of a group of people. Health and Social care commissioners and service providers need to acknowledge the nuanced multiple systems of oppression that racialised people with Intellectual Disabilities and Autism contend with in their quest to receive personalised services. Service designs that treat people with intellectual disabilities as a homogenous group are insufficient for those simultaneously experiencing racism and other categories of disempowerment, (Viruell-Fuentes, Miranda and Abdulrahim, 2012).

Robbins (2019) identifies the trauma associated with approaching oppression from a singular dimension without acknowledging the intersection of multiple oppressions. A significant part of the oppression of people with intellectual disabilities emanates from welfare policies which treat them as commodities within a neo liberal health care economy, (Robbins 2019). Adult Social Care in based on the premise of cost effectiveness and services for people with Intellectual Disabilities are provided on the basis of restricted budgets rather the needs of the person. The case study cited here is an example where restrictions in health and social care budgets translate to delays in meeting the needs of a disadvantaged person. Waiting lists often occur as a result of cost savings efficiency plans which reduce the multi-professional staffing levels of community intellectual disability support teams. In the neo-liberal engineered austerity environment, therapy focused professions such Occupational Therapists and Dramatherapists are considered to be superfluous in some health and social care teams. However, for a person with intellectual disabilities and neurodivergence, these professionals can make the difference between a life well lived and a poor quality of life.

In the context of this case study, the young person had access to psychiatric services and was prescribed an antipsychotic drug, risperidone whose possible side effects include agitation, (British National Formulary, BNF, 2022). However, there was no service made available to him and his family as soon as he required help to identify the triggers or functions of his distressed behaviour and how these could be mitigated against. Afuape, (2011) describes this as psychiatric power which can become oppressive, adjusting individuals with intellectual disabilities to unjust circumstances. It is widely acknowledged that people with ASC often perceive their sensory environment in ways that are different from neurotypical people. Medication may be prescribed to make them adjust to environments that are not suited to their needs. Most intellectual disability services are led by neurotypical people who decide how best people who are neurodivergent should be supported sometimes without relevant assessments to inform their decisions.

The young person in the case study was assessed as having sensory processing difficulties. Sensory processing is about how the brain interprets the feel, sounds, tastes, sights and smells of things that are constantly being sensed from both inside and outside the body, (Bogdashina, 2003). The senses include the familiar ones such as touch, vision, sound, taste, smell and the less familiar vestibular and proprioceptive senses. When a person has sensory processing difficulties, what neurotypical people perceive as non-threatening sensations may become more apparent and problematic. The brain triggers the body to go into fight, flight or freeze mode in an attempt to eliminate the threatening sensations, (Bogdashina, 2003). Repeated experiences of this nature may manifest as behaviours that other people perceive as challenging. The young person in our case study was assessed as being hypersensitive or over-responsive to sound stimuli. To a person experiencing this, noise can be magnified, and sounds become distorted and muddled. Furthermore, they may be unable to cut out background noises leading to sensory overload and distress. If this knowledge had been available to his parents and support workers prior to attending the swimming activity, steps could have been taken to ensure that the noise levels in the swimming baths and changing rooms was managed. In the review of the circumstances surrounding the incident of Ayobami assaulting a child in the changing room, it was noted that the child had been using a hairdryer at the time of the attack. The noise of the hairdryer most likely triggered the attack. To the neurotypical observers, it appeared that Ayobami had assaulted a child for no apparent reason.

Neurodivergent people with intellectual disabilities are often disabled by ill-fitting environments which are designed for the health and well-being of neurotypical people, (Silberman, 2015; Higashida, 2014 & 2017). In reviewing the case study, it can be noted that the young person with intellectual disabilities and Autism was known to love swimming. However, his local community swimming facilities were not designed for a person with hyper-sensitivity to sounds, sight and a risk of over-stimulation. If community environments are not adjusted to suit neurodivergent people, then there is a real risk of people being locked away in assessment and treatment units for displaying distressed behaviours. The Transforming Care agenda, (NHS England, 2015) was meant to enhance the capacity of community health &

social care service provision thereby facilitating the closure of long stay hospitals and assessment and treatment centres. However, people with intellectual disabilities and autism spectrum conditions are still being placed in locked hospital units for what is usually referred to as ‘challenging behaviour’. The Care Quality Commission, (CQC, 2020) released a report which noted that people with intellectual disabilities, mental health conditions and autism often did not receive appropriate health and social care support from an early age. The report highlighted that some families were left in crisis until locked hospital units became their only viable option for support. Hospital environments are usually busy and noisy which then has a long-term detrimental effect on people’s mental well-being especially for those with autism.

The placement of young people with intellectual disabilities and ASC in locked hospital units may have a negative impact on their emotional wellbeing. In the case study under review, it was noted that Ayobami had never been separated from his nuclear family for longer than a few days since birth. He was admitted onto a hospital unit at least 3 hours drive away from his parents and known circle of support. It was noted that his initial weeks in the assessment and treatment unit were characterised with an escalation in displays of behaviours which included hitting, kicking, throwing things and loud vocalisations. These behaviours could have been Ayobami’s communication of distress. With every accommodation change people with intellectual disabilities may experience the loss of their routines, family life, friendships and circles of support, (Dodd, Dowling and Hollins, 2005). These losses may threaten their security and result in grief reactions especially where there is a desire to return home, (Murray, 2001). People who do not rely on others for their care, may be able to work through their own losses however, a person with intellectual disabilities and ASC may be unable to do so. Furthermore, within a hospital context they may be under continual supervision, receiving interventions, interruptions and disruptions even when they need their own privacy and space, (Shah, 1998). They may also be negatively impacted by the distress of other people within the locked hospital units. Sinason, (2012), in an influential study demonstrated that people with intellectual disabilities possess significant emotional intelligence. This is the capacity to understand one’s own emotions and the emotions of others. The testimonies of Higashida (2014;2017), dispel the myth that people with ASC live in their own world and are not able to respond to the emotions of others. Unfortunately, society may at times deny their pain and not respond to their behavioural demonstrations of emotional distress, (Sinason, 2012). There are physical and emotional reactions to loss which cannot be ignored, (Wright, 2002). Health and social care staff working with people in locked hospital units need to empower them to build new relationships and create a nurturing environment where care needs are anticipated and met appropriately, (Goldbart and Caton, 2010),

People with ASC are at risk of coming into contact with the criminal justice system when their individual needs are not being appropriately met. This risk is heightened for young black men (Lammy, 2017; Gilborn, 2015). The increased rates of incarceration for black men is a devastating example of socially constructed borders of racism built on socially constructed borders of risk, where the rationale of harm to self and others takes on a moral imperative. Although people with both ASC and Intellectual Disabilities may be subject to safeguarding processes that divert them from prisons, they are still at risk of incarceration in long stay locked assessment and treatment units. Research with people with Intellectual Disabilities is often invisible to neurotypical people. This invisibility is compounded when the person with an intellectual disability also comes from a racially minoritised background. In the absence of reputable evidence, assumptions about young black people may normalise the manifestations of harmful behaviours. Ayobami was assaulting people including family members and paid staff without getting specific support for his distressed behaviours. This may have reinforced unhelpful stereotypes of violence amongst young black men, (Welch, 2007).

Bogdashina, (2003), identifies the flaws in interpreting the behaviour of people with autism using a non-autistic lens. Often displays of distress in people with intellectual disabilities and neurodivergence are received with behaviour modification plans which at times locate the solution to the distress within the person. Schmidt & Weiner (1988) replicated an experimental investigation that confirmed the impact of attributions on helping behaviour. Their research determined that when a person needs help, their potential helper seeks to determine why they need help. If the reason for the person needing help is judged as uncontrollable and the person is deemed to be unable to help themselves, then sympathy is elicited which in turn triggers helping behaviours, (Schmidt & Weiner 1988). However, the converse is true, if the reason a person needs help is judged to be inherently controllable and the person is assumed to be able to help themselves, their potential helper will experience negative emotions such as anger, disgust, resentment which in turn leads to them withholding their help. The label a person is given will often dictate the intervention they receive from health and social care professionals. Assumptions are often made that behaviours need to be moulded rather than seeing them as distressed responses and trauma caused by ill-fitting environments. There is not enough acknowledgement of the trauma that people with intellectual disabilities and neurodivergence have experienced whenever their needs are mis-recognised and mis-diagnosed.

Higashida, (2014; 2017) raises an interesting observation about how neurotypical people often assume that people with severe ASC have severe intellectual disabilities because of their difficulties with social communication. Testimonies from some people with lived experience of ASC, point to an emerging concept that people with ASC may at times have a severe sensory processing impairment which is mis-labelled as a severe cognitive impairment, (Higashida, 2017). Assumptions are then made that the person is unable to make informed decisions about their daily lives. This is more prevalent in people who communicate non-verbally or those whose expressive language consists of a few phrases. There is an ever present need to adopt Total Communication Strategies in a person-centred manner.

Minh-ha & Trinh, (2010), note that for all the talk about the world becoming a global village, there are now more boundaries and borders created to shut out and exclude those who are deemed to be foreigners. This is more pronounced for people who look different, speak with a different accent and have foreign sounding names. Often people’s names will be changed for the convenience of English-speaking people who state that they cannot pronounce their full names. Ayobami’s name was changed by all the staff who worked with him the only exception being two Black African workers who used his given name. It is noted within minority communities that names are important in the building of a positive self-image. Where people do not acknowledge one's real name it conveys a subtle meaning of that name not being of value. Furthermore, in the context of people with intellectual disabilities and ASC, using the person's correct name is crucial for obtaining their attention prior to communicating a message to them, (National Autistic Society, 2022). Health and Social care services should be at the forefront of promoting diversity rather than attempting to anglicize the names of racialised or minoritised people. Minh-ha &Trinh (2010:46) conclude that "despite all the conscious attempts to purify and exclude, cultures are far from being unitary, as they have always owed their existence more to differences, hybridities and alien elements."

Gilborn, (2015) notes that a person with an impairment is usually disabled by socially constructed problems and assumptions. Referring back to the case study under discussion Ayobami was disabled by the following;

1. There was no current or historic assessment of his behaviours and their functions. People with Intellectual Disabilities and ASC often communicate through their behaviours. Silberman, (2015), explains that for a person with ASC accessing verbal descriptions of what is going on internally is difficult. Ayobami's behavioural whispers were ignored thereby causing him to engage in behavioural shouts. He was triggered into displaying behaviours whose high frequency, duration and intensity were impossible to ignore.
2. There was no sensory integration assessment to enable the adaptation of his environment such that he would not be traumatised. For a person with ASC the mainstream world may be an unending sensory assault (Silberman, 2015).
3. The family had never been given any Autism Awareness training or empowered to understand how Ayobami's ASC would impact his daily living. The reality for many families may be that when their child was given an ASC diagnosis, it was in the context of bad news thereby destroying their hopes for the future of their child.

4. There had been no multi-professional/ multi-agency approach to Ayobami's care and support since he transitioned from children's services.
5. There was an assumption that Ayobami's parents were able to identify and purchase suitably qualified staff to provide support for him. It was assumed that the individual budget would benefit Ayobami and improve his quality of life. There was no corresponding support from the local authority regarding the suitability of services purchased for Ayobami
6. There was limited Autism specific planning for the swimming activity. Ayobami was not given enough cues about the activity and how it would be structured. Silberman, (2015) notes the efficacy of visual schedules in supporting a young person with Autism to predict their day thereby enabling them to manage the activities planned on their behalf. The incident at the swimming pool led to his access being ended due to his 'aggression'. However, there was no active acknowledgement that the set-up of the environment triggered him. He was in effect blamed for experiencing sensory overload and distress. Locating the problem inside the person with ASC and Intellectual disability leads to interventions that deny the true nature of distress.
7. There was a long waiting period for Ayobami and his family prior to the provision of a specialist Intellectual Disability and ASC support service.

In the history of services for people with intellectual disabilities there has been a drive towards social role valorisation, citizenship and the empowerment of individuals by giving people choice and control over their support provision. Direct payments and individual budgets became the natural development of these ideas. However, in the provision of Health and Social care services for people with Intellectual Disabilities, the tentacles of neoliberalism have at times become a constraint. Cummins (2018) points out that a key feature of neoliberalism is the concept of promoting choice and control for individuals with minimal state intervention. The reduction in state led public services has however not led to an increase in choice or control for marginalised communities. It has instead promoted and further enriched affluent, dominant groups at the cost of the poor and disadvantaged, (Thompson, 2018). Venugopal, (2015) argues that neoliberalism's depiction in Social Sciences has become problematic as the term has been used in many different conflicting scenarios. As such the term cannot be accurately used to explain economic phenomena. Neoliberalism can instead be viewed as a thought collective that seeks to influence states and organisations away from the threat of total state control, (Dean, 2014). Notwithstanding, even if the term neoliberalism was no longer used in Social Sciences, the reality for people with intellectual disabilities in need of services remains unchanged. The decision to give carers and people with Intellectual Disabilities personalised budgets must be accompanied with empowering services that facilitate informed choice. Services are not always set up to meet the individual needs of people who are perceiving the world through a neurodivergent lens. Individual budgets are meant to empower marginalised groups of people however, where there are no commissioned service providers who are proficient in understanding the intersectional experience of a person with intellectual disabilities, the whole idea of personalised services becomes an illusion. People with intellectual disabilities and their carers need sufficient knowledge in order to benefit from the free market. The ideals of the government in the UK, regarding the personalisation of health and social care services have at times appeared to be utopian. Ferguson, (2007), notes that the term Personalisation did not emanate from the social work collective and that the agenda did not recognise the impact of structural inequalities. Furthermore, multiple discrimination, lack of resources and cognitive impairments reduce the capacity of people in need of services to become the authors of their own destiny, instead the personalisation agenda arguably makes them more dependent on public services. “It is clear therefore that structural inequalities of the scale we see in the world could not exist or remain without certain ideas being perpetuated,” (Afuape, 2011:28). In the United Kingdom neoliberalism has dominated the provision of health and social care services in recent years. The privatisation of public services has been seen as crucial for creating efficient services. Additionally, budget cuts to social services and the national health service have been relentless. Thompson, (2018), notes that because of these policies inequality is increasing rapidly.

The neo-liberal welfare policy of awarding people in receipt of Health and Social care services individualised budgets or direct payments is based on the assumption that disadvantaged people can become self-reliant without support from the public sector, (Robbins, 2019). In the case study, Ayobami’s parents were expected to undertake an assessment of the needs of their son, devise a suitable risk assessment and make the right choices in terms of purchasing his support. Assumptions were made that they had sufficient knowledge of Autism Spectrum Conditions, (ASC) and responding to complex distressed behaviours. In view of Ayobami's long awaited assessments from community health services, his parents would have been unable to make informed service choices with his allocated direct payment. One cannot purchase a good service without a full understanding of the needs which are to be met by that service. You cannot exercise choice with your hands tied by a limited budget and inflexible service structures. This leads to a systemic disempowerment of marginalised communities, where people are treated the same without promoting equality. Neoliberalism is not colour-blind and has a disproportionate negative impact on racialised minority groups, (Cowden & Singh, 2017). The status quo cannot be maintained if it enables the further disempowerment of disadvantaged groups of people, (Wesp, Ruiz, Weitzel, Kako and Mkandawire-Valhmu, 2018).

The adequate resourcing of Community Teams who support people with Intellectual Disabilities is crucial for mitigating against intersectional oppression. Cummins (2018) notes that in the neo-liberal context of the UK, public sector workers are often portrayed as draining national resources with big pensions and generous pay. This rhetoric is then used to justify reducing personnel in Health and Social Care teams that are meant to provide a valuable service to people with Intellectual Disabilities. A false economy is presented whereby people's health challenges are left to escalate and become a crisis for people with lived experiences as well as Health and Social Care service providers. In the case study under review, the weeks that Ayobami was awaiting assessments and support for his distressed behaviours eventually culminated in a placement at an Assessment and Treatment locked hospital unit whose weekly cost was in excess of £3 500 per week. Furthermore, there was an additional immeasurable cost in emotional distress and trauma for himself, the child he hit, the child's family, Ayobami's family, the support workers, professionals and those impacted by the series of events. Adequate resources are required to ensure that people receive timely support within their communities.

Developing a fit for purpose workforce within Health and Social Care is a vital piece of the tapestry of services that are able to respond to intersectional marginalisation. In the case study under review the young person was supported by workers with no training in how to work with neurodiversity. The young person was expected to fit into the usual pattern of support provided to 9 other people. The whole group of 10 people was expected to conform to a programme structured for uniformity rather than diversity. In instances where public bodies have taken a similar approach to the delivery of care, it has been rightly labelled as institutional discrimination. The success of the swimming activity in our case study relied on the compliance of the 10 individuals with intellectual disabilities. There is a common expectation that people with intellectual disabilities should acquiesce, accept or even be grateful for any sort of support given to them by non-disabled people. Compliance is expected and any form of dissent would be labelled as challenging behaviour which needs to be addressed and corrected. There is a need for adopting the concept of Deep Democracy within services in order to respond to the intersectional experiences of people with Intellectual Disabilities.

The concept of Deep Democracy advocates for an attitude that focuses on both central and marginal voices, (Mindell,1992). It is unlike “classical” democracy, which focuses on majority rule. Deep Democracy suggests that all voices, states of awareness, and frameworks of reality are important (Mindell, 2002). Therefore, our communities would tune in to neurodivergent voices in their expressions of distress. Often when people with intellectual disability and neurodivergence express distress they are pathologized and labelled as displaying challenging behaviour. The communication abilities of people with intellectual disabilities and autism will vary. As such a total communication approach is required to receive messages and encode messages back to the sender. This could include the use of communication dictionaries, the Picture Exchange System (PECS), talking mats as well as other forms of augmentative and alternative communication (AAC) systems.

There is a paucity of Health and social care provision specific to race, disability and neurodivergence. Invariably this leads to misrecognition of needs, misdiagnosis and increased risks as noted in the case study. Black autistic people are often invisible in health and social care policy with their intersectional complexities downplayed. Ellis (2021) notes that parents from racialised communities often have heightened concern for their children while they go about routine daily living activities. This concern would be much more emphasised where that child is considered by society to be a deviation from the norm in terms of race and ability. If services focus on anti-disablist policies which do not address the specific needs of racialised minority groups the phenomenon of "strategic silence" takes place, (Crenshaw, 1991). That is to say that the discrimination of racialised people is ignored or only used to advance the causes of more dominant groups. Bourdieu (1984) suggests that people who are familiar with the accepted and celebrated culture of a society, possess cultural capital which accords them certain privileges and opportunities in the community. Kisida, Greene, and Bowen, (2014) note that neurotypical young people may be able to experience some cultural mobility when exposed to educational opportunities and experiences. A young person with intellectual disabilities and neurodivergence may be unable to understand the accepted culture of their society. This may be more pronounced for those young people whose parents are first generation migrants in the United Kingdom. They may lack embodied cultural capital in terms of their command of the English language, mannerisms and preferences, (Bourdieu,1984; Kisida, Greene, and Bowen, 2014). This can impact on how well they are able to articulate and communicate their needs and challenges to Health and Social Care professionals. As a result, cultural capital inequalities reproduce inequalities in health and social care provision, (Kisida, Greene, and Bowen, 2014).

The multicultural nature of our contemporary society could lead to the fallacy that human experience is becoming more generic and that universal services can become more generic and serve different groups of people equally, (Walsh, 2010). There is also the trap of assuming that ethnicity refers to some permanent essence attached to minorities that becomes deterministic (Walsh, 2010). This needs to be counteracted by person centred co-produced ways of working with minority groups which include antiracism; anti-oppressive/anti-discriminatory practice;

interculturalism/multiculturalism; and human rights activism (Walsh, 2010; Williams, 2021). Viruell-Fuentes, Miranda and Abdulrahim, (2012), note the need for nuanced services which consider the impact of immigration and racialisation on the health and social care outcomes of people. Indeed, when families emigrate, they usually lose the support systems that they relied upon for their socio-economic and health needs. In the context of the case study under review, the family experienced a destruction of their extended family support system through migration. Their African community was built around the concept of Ubuntu, which is not always present in the United Kingdom. Ubuntu is a Sub-Saharan philosophy that embodies the honouring of the personhood of others and the acknowledgement of our interconnectedness within society, (Gade, 2012). It is the idea that one’s personhood derives from that of others within their community. As such any threat on the personhood of an individual member would have an impact on the whole collective. There is a pooling of community resources to support disadvantaged members of the social group. First generation migrants in the UK often find themselves isolated. The barriers that are put in place by harsh immigration policies, austerity measures and racist neo-liberal agendas may mean that some people with significant care needs do not get the support they need in a timely manner (Viruell-Fuentes, Miranda and Abdulrahim, 2012).

People with intellectual disabilities, neurodivergence and minority labels are not a homogenous group. They will have varied experiences of oppression however, there are intersectional common denominators that are experienced by the group, such as difficulties communicating their wishes to a world that is geared towards neurotypical people. An understanding of this should prompt health and social care workers to stand in solidarity with them. Solidarity is not an act of pity or charity but rather the recognition that social justice benefits all those who are involved, (Osman, 2018). The root cause of oppressions whether they based on colour, disability or neurodivergence are the systems that govern health and social care delivery. As such where systemic change is effected, positive outcomes are experienced by all members of the society regardless of their intersectional experience.

The convergence of racist, disablist, elitist neo-liberal agendas increases the risk of incarceration for black people with intellectual disabilities and autism. Therefore, unless the structures that reproduce discrimination and inequality are dismantled person-centred success stories may remain a novelty. There is an urgent need to implement anti-racist social work which embraces difference and listens to the communication of people with intellectual disabilities. Health and Social Care services ought to move away from a model of labelling behaviour and medicating people but rather take a therapeutic approach that responds to the distress of people with intellectual disabilities and neurodivergence.

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