OKLAHOMA CHILD WELLBEING • DISABILITY, SAFETY & AUTONOMY

Understanding Disability

A practical guide to disability, support needs, language, access, and self-determination

Evidence-informed • person-centered • rights-respecting • plain-language

CORE IDEA

A disability is one part of a whole person. A diagnosis can describe a condition or support need; it cannot tell you the person's values, goals, intelligence, preferences, relationships, or potential.

1. What disability means

Disability is not one single experience. The CDC describes disability across impairment, activity limitation, and participation restriction. The World Health Organization emphasizes that disability also reflects the interaction between a person's health condition and environmental and personal factors. In practice, the same condition can affect two people very differently, and the same person's support needs can change across settings and over time.

- A body or mind difference may affect vision, hearing, movement, learning, memory, communication, mental health, social interaction, self-care, or other activities.
- Barriers in the environment—stairs, inaccessible websites, complex language, lack of interpreters, rigid rules, stigma, or poor transportation—can increase disability-related limitations.
- Accommodations, assistive technology, accessible communication, supportive relationships, and inclusive environments can reduce barriers and increase participation.
- Some disabilities are apparent; others are non-apparent or fluctuate. A person should not have to "look disabled" to have legitimate access needs.

2. Major disability categories

Developmental disabilities

A group of conditions beginning during the developmental period that can affect physical, learning, language, or behavioral functioning. Examples can include autism, cerebral palsy, intellectual disability, and other developmental conditions. A person may have more than one developmental disability.

Intellectual disability

AAIDD describes intellectual disability as significant limitations in intellectual functioning and adaptive behavior that originate during the developmental period. Adaptive behavior includes conceptual, social, and practical skills. Support needs vary widely; diagnosis alone does not establish what a person can decide or do.

Physical and mobility disabilities

Conditions that affect movement, strength, stamina, dexterity, coordination, or physical functioning. Some people use wheelchairs, walkers, prostheses, personal assistance, or other supports.

Sensory disabilities

Includes blindness/low vision, Deafness/hard of hearing, deafblindness, and other sensory differences. Access may require large print, Braille, audio, captions, sign language, tactile communication, or accessible digital formats.

Communication disabilities

A person may communicate through speech, sign language, writing, gestures, communication boards, speech-generating devices, augmentative and alternative communication (AAC), or a combination. Speech is not the same thing as understanding or intelligence.

Learning and cognitive disabilities

May affect reading, writing, mathematics, attention, processing speed, memory, executive functioning, or other cognitive tasks. The person may need information presented differently, more time, repetition, visual supports, or reduced cognitive load.

Mental-health-related disabilities

Mental health conditions can substantially affect major life activities and may qualify as disabilities. Needs can be episodic and may vary with stress, environment, treatment, and supports.

Chronic health and episodic disabilities

Long-term health conditions can cause disability through fatigue, pain, neurological effects, breathing limitations, seizures, autonomic symptoms, or other functional impacts. Some conditions fluctuate, so support needs may not be constant.

3. Person-centered and strengths-based practice

Person-centered planning begins with the person—not the service system. The Administration for Community Living describes person-centered planning as directed by the person receiving support and focused on strengths, goals, needs, preferences, desired outcomes, culture, relationships, community life, and appropriate risk.

- Ask the person what matters to them before deciding what support should look like.
- Identify strengths, skills, interests, relationships, and successful strategies—not only deficits or risks.
- Offer meaningful choices in a format the person can understand and use.
- Use the least restrictive support that effectively addresses the need.
- Revisit supports. A strategy that was appropriate at one age, in one setting, or during one crisis should not automatically become permanent.
- Include the person in planning to the maximum extent possible, including when a legal representative is involved.

4. Language: person-first, identity-first, and respectful description

There is no single language preference shared by all disabled people. NIH guidance notes that both person-first language (“person with a disability”) and identity-first language (“disabled person,” “Autistic person”) are used. Recent research also shows that preferences differ across people and disability communities.

- When you know the person’s preference, use it.
- When you do not know, ask respectfully when practical. NIH defaults to person-first language when preference cannot be determined.
- Avoid euphemisms such as “handi-capable” or “differently abled” unless a person uses that language for themself.
- Avoid “wheelchair-bound.” A wheelchair is often a tool for mobility and access; use “wheelchair user” or “person who uses a wheelchair.”
- Describe support needs specifically instead of using vague labels such as “high functioning” or “low functioning.”
- Do not infantilize adults. Use age-respectful language, tone, activities, and choices.

5. Communication access is a safety issue

Effective communication is not an optional courtesy. Under the ADA, covered state/local government entities and public accommodations have duties related to effective communication. The appropriate aid or service depends on the nature, length, complexity, context, and the person’s usual communication method.

- Speak directly to the person, not only to a companion, interpreter, or support worker.
- Ask: “How do you prefer to communicate?” and “What would make this easier to understand?”
- Allow processing time. Do not treat slower response time as lack of understanding.

- Use plain language, short chunks, concrete examples, visual supports, repetition, or teach-back when useful.
- Honor AAC, sign language, captions, large print, Braille, screen-reader-compatible documents, or other access methods.
- For important or sensitive communication, do not assume a family member is an adequate substitute for a qualified interpreter or other required aid.

> **SAFETY CONNECTION**
> A person who cannot privately communicate, understand information, or reliably reach someone outside a caregiving system can face greater barriers to recognizing and reporting harm. Access to communication is therefore part of prevention, autonomy, and accountability.

6. Support needs are not fixed

Support needs can change with age, health, fatigue, stress, environment, familiarity, communication demands, sensory load, trauma, medication effects, or the complexity of a decision. A person may independently handle one task and need substantial support for another.

- Do not generalize from one skill to every domain.
- Do not interpret needing help as inability to participate in decisions.
- Break complex tasks into steps and identify exactly where support is needed.
- Build skills and access before restricting choices.
- Document what helps the person succeed so effective supports can follow them across settings.

7. Supported decision-making

Supported decision-making (SDM) is an approach in which a person retains decision-making authority while receiving help from trusted people they choose. ACL describes SDM as an alternative to guardianship for some people and emphasizes that support should be tailored to the decision and the person.

- Support can include explaining options, comparing consequences, gathering information, communicating a choice, remembering preferences, or involving trusted supporters.
- Support is not the same as substitution. The supporter should help the person decide—not quietly make the decision for them.
- Risk alone does not eliminate autonomy. Person-centered planning includes discussion of appropriate risk, safeguards, backup plans, and learning.

Legal authority and guardianship rules vary by state. SDM should be considered within applicable law and the person's circumstances.

8. Disability, risk, and protection from harm

Disability should never be treated as the cause of abuse. Harm is caused by people and systems that abuse power, exploit dependence, ignore warning signs, or fail to provide accessible ways to seek help. Research does show elevated violence exposure among children with disabilities. An updated systematic review and meta-analysis of 98 studies found an overall violence prevalence of 31.7% and about twice the odds of violence compared with children without disabilities, while also reporting substantial heterogeneity across studies.

- Prevention should reduce opportunities for abuse without unnecessarily reducing the person's freedom.
- Build multiple safe relationships rather than concentrating all information and control in one person.
- Teach rights, boundaries, consent, privacy, and how to seek help in accessible ways.
- Create private opportunities to communicate with professionals when appropriate.
- Take disclosures seriously and adapt interviewing/reporting processes to the person's communication needs.
- Monitor services for quality, safety, effectiveness, and respect for rights.

9. Practical checklist: Is this support actually person-centered?

- ☐ Does the person know what decision is being made?
- ☐ Was information provided in a form the person can understand?
- ☐ Was the person asked what they want—not only what others think is safest?
- ☐ Are communication needs and accommodations in place?
- ☐ Are strengths and existing skills being used?
- ☐ Could a less restrictive support address the concern?
- ☐ Does the person have more than one trusted person or route for help?
- ☐ Can the person communicate privately when needed?
- ☐ Are risks explained without using fear, shame, or threats?
- ☐ Is there a plan to review whether the support is still needed?

10. For professionals, families, and systems

A strong disability-support system does more than prevent immediate harm. It increases a person's ability to understand, choose, communicate, participate, build relationships, recognize danger, and reach help.

- Design for access from the beginning instead of waiting for a person to fail in an inaccessible system.
- Measure meaningful outcomes: participation, choice, safety, relationships, communication access, quality of life, and goal attainment.
- Include people with disabilities in program design, training, policy development, and evaluation.
- Separate genuine safety requirements from organizational convenience or paternalism.
- Treat dignity, privacy, autonomy, and protection from abuse as connected goals.

IMPORTANT

This resource is educational and is not individualized medical, legal, mental-health, or emergency advice. Disability does not by itself determine a person's decision-making or consent capacity. Laws on age of consent, sexual consent, guardianship, mandatory reporting, and decision-making capacity vary by jurisdiction. In an emergency, use local emergency services.

References & trusted sources

Research hierarchy used: government/public-health guidance and disability-rights standards; systematic reviews/meta-analyses; professional consensus/position statements; then supporting peer-reviewed studies. Evidence strength and limitations are stated where important.

1. Centers for Disease Control and Prevention. Disability and Health Overview (2025). Source
2. Centers for Disease Control and Prevention. Developmental Disability Basics (2026). Source
3. World Health Organization. Disability and health fact sheet. Source
4. Administration for Community Living. Person-Centered Planning. Source
5. Administration for Community Living. Supported Decision Making Program. Source
6. U.S. Department of Justice. Communicating Effectively with People with Disabilities. Source
7. National Institutes of Health. NIH Style Guide: Disabilities (reviewed 2025). Source
8. AAIDD & The Arc. Individual Supports position statement (2023). Source
9. Fang, Z. et al. Global estimates of violence against children with disabilities: updated systematic review and meta-analysis. Lancet Child & Adolescent Health (2022). Source
10. Aston, P. et al. Experiences and perceptions of everyday decision-making in adults with intellectual disabilities: systematic review (2023). Source
11. United Nations. Convention on the Rights of Persons with Disabilities (CRPD). Source

EVIDENCE NOTE

“Gold standard” does not mean every disability topic has randomized-trial evidence. For rights, communication access, person-centered practice, and consent, the strongest available evidence often combines law/policy standards, systematic reviews, lived-experience research, and professional consensus. Where research is limited, this guide says so rather than presenting certainty that the evidence does not support.

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