ROLE OF INDEPENDENT LIVING IN REHABILITATION

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Jeff Gunderson's voice is choked with worry. He is about to reenter the place he called "A concentration camp." It is a nursing home, one of two where Gunderson, who has cerebral palsy, was sent from the time he was eighteen until he turned twenty-seven.
Shapiro, 1994, p. 237

OVERVIEW

Independent living can be defined as the ability of a person with a disability to perform self-care activities and participate in the process of self-determination in the least restrictive environment (Wright, 1980). The term most commonly refers to living in the community and not in an institution. In addition, independent living is an attitude, an ideology, and a socio-political movement of global dimensions. The philosophy of independent living is based on honoring the rights of people with disabilities to equal opportunities, empowerment, and self-respect. This is in absolute congruence with the fact that people with disabilities are experts on their own lives, and that they have the right to assume full control over their lives. The true motto is to ensure that people with disabilities have the same rights and choices as their counterparts without disabilities (Nosek, 1997; Ratzka, 1997).

The Constitution of the United States established certain inalienable rights such as the right to life, justice, liberty, and the pursuit of happiness. In spite of these guarantees, many Americans have historically had to prove their worth to attain these rights, particularly if they were disabled, poor, or members of a
disempowered minority. People with disabilities are certainly no exception in the sense that they had to purchase social equity with the lives of many persons (Brown, 2001).

Freedom is always an expensive commodity (Lachat, 1988). At the turn of the Twentieth century, sexual segregation of people with mental and physical disabilities was commonplace. Forced sterilization of those with mental illness and epilepsy became popular in 1910 and was legalized in 1937 by 28 states. Legislation was passed in some states banning the public appearance of "defective" people. People with deafness were barred from becoming witnesses in a trial or serving on a jury (Curtis, 2001; Shapiro, 1994). The cost of enabling persons with disabilities to live freely has traditionally been considered too high.

By their very nature, institutions such as nursing homes are built on the medical model. Many are restrictive, paternalistic, and suppressive of the pursuit of happiness (Brown, 2001; Curtis, 2001). This underprivileged and "dependent caste" status has resulted in less education, high unemployment, and substandard living conditions, which collectively result in a low quality of life among persons with disabilities (Shapiro, 1994). At the beginning of the Twentieth century, this legalized dependency and ostracism had been challenged unsuccessfully by legislation and uncoordinated efforts of well meaning people. By the mid 1900’s, people with disabilities felt a strong urgency to unify and organize a movement to dismantle institutionalization and promote integration in the mainstream of society (Curtis, 2001; Ratzka, 1997). In this context, Ratzka (1997, p. 1) states that “We are the last minority to fight for our rights and we will not go away. Even with the most sophisticated prevention, early detection and rehabilitation services, there will always be people with disabilities and we have to build our societies in such a way that everybody can live in them with dignity and self-respect. And we have to start now.”

**HISTORY OF THE INDEPENDENT LIVING MOVEMENT**

Deinstitutionalization, the driving force behind the independent living movement, is an attitude that focuses on independence, mobility, individuality, self-determination, empowerment, and integration into the mainstream of society (Shoenfeld, 1975). The term denotes the process of keeping individuals with disabilities in the community and reducing dependence by creating
programs to address their overall developmental needs. It strives to establish appropriate community-based living infrastructures so that consumers, especially those with significant disabilities, can receive services in the least restrictive environment (Wright, 1980).

The seed for the independent living movement was sown in the early 1960s when a student with respiratory quadriplegia secondary to polio enrolled at the University of California, Berkeley. Ed Roberts, who used an iron lung, became the first student with a significant disability to be admitted to an American university. To publicize this important milestone, a local newspaper printed an article entitled *Helpless Cripple Goes to School.* By 1965-66, due in large part to the active involvement of Ed Roberts and a few service providers in the community, the enrollment of students with disabilities increased considerably. By 1969, the Cowell Residence Program supported by the California Department of Rehabilitation, grew to 12 disabled students. This program, housed at the Student Health Center, provided sheltered living and resembled the supervised conditions of an institution. The students' movements were confined to a largely inaccessible campus. The total effect of the situation resulted in the students becoming increasingly aware of the lack of control that they had over their own lives. This increased their need for self-determination (Brown, 2001; Zukas, 1975).

In the fall of 1969, the students organized a "Strategies for Independent Living" class under the university's group study program. The primary aim was to develop a proposal for establishing a facility similar to the Cowell Resident Program but under the direct control of residents. The program was open to non-residents as well. Upon investigation, Ed Roberts learned that the U.S. Office of Education offered assistance to disadvantaged students and was interested in allocating 10% of its funds to services for students with disabilities. The students wrote a proposal to secure funding for a Physically Disabled Students' Program (PDSP) that adopted a holistic and integrated approach to service provision. The three main philosophical traits of the program were (a) people with disabilities are the experts in identifying their needs and the ways to address them, (b) the needs of those with disabilities can be addressed via comprehensive programs providing a wide array of services, and (c) people with disabilities should be fully integrated into society (Shapiro, 1994; Zukas, 1975).

Due to the encouragement of PDSP, a group of disabled individuals met in 1971 to discuss the establishment of a community-based service program. They called it the Center for Independent Living (CIL). The CIL was designed as a coalition of people with all types of disabilities working toward a common goal. Once the conceptual framework for the center was in place, a source of funding became the main concern. Three months after its incorporation in 1972,
the CIL was awarded a one-year $50,000 grant by the Rehabilitation Services
Administration to develop a comprehensive service program (Brown, 2001;
Curtis, 2001; Zukas, 1975). This center currently provides peer counseling,
advocacy, independent living skills training, attendant referral, transportation,
health maintenance counseling, housing referral, and wheelchair repair services
(Nosek, 1997).

Concurrently with the University of California at Berkeley, students with
disabilities at the University of Illinois at Urbana-Champaign started working
toward the establishment of community living facilities. This resulted in the
transfer of four students with disabilities from a nursing home to a modified
house near campus. This student activism helped the university to become one
of the most accessible campuses in the country (Nosek, 1997).

**LEGAL MANDATES RELATED TO INDEPENDENT LIVING**

The concept of independence, the goal of the total rehabilitation process, is
considered the key to growth and maturity and a required stepping-stone to
adult life. Vocational rehabilitation is designed to be a means of freeing oneself
from both unwanted dependence and the restrictions imposed by social and
environmental forces. As per Martinez (2003), independent living philosophy
professes that each person has the right to independence through maximum
control over his or her life by making choices in performing everyday activities.
These activities may include managing one's personal life, participating in
community life, fulfilling social roles, enhancing self-determination, and
minimizing physical/psychological dependence. Despite the desirable qualities
of self-determination, the positive aspects of dependency in the lives of humans
as social beings cannot be completely overlooked. The proper balance of
dependence, independence, and interdependence is required to satisfy our
physical and psychosocial needs. Excessive dependency, defiance, or excessive
independence, however, can result in non-achievement of one's rehabilitation
goals (Wright, 1980; Wright, 1983).

Since the early 1960s, it was believed that the independent living
movement had the potential to emancipate not only persons with disabilities but
also millions of other disadvantaged Americans. During the past few decades,
the movement has become a powerful force devoted to promoting the
philosophy of consumer control, equal access, and self-reliance as the building
blocks of independent living for those with disabilities (Lachat, 1988).
A significant factor that contributed to the development of the independent living movement was the formation of social organizations such as clubs and sports groups. These entities provided excellent networking opportunities and tended to increase the sense of unity and commonality for people with disabilities. The current cross-disability social change groups and independent living centers grew out of associations for athletes with disabilities (Independent Living Research Utilization, 1999).

The independent living movement gained strength with the passage of the Rehabilitation Act of 1973. The major thrust of this Act was integration, mainstreaming, and holistic participation at all levels in society. The legislation mandated services to persons with severe disabilities, post-employment services, protection of client rights, promotion of consumer involvement, protection of the civil rights of persons with disabilities, and support for research. The word "vocational" was deleted from the Act in order to meet the needs of those individuals with significant disabilities (Schiro-Geist & Kundu, 2006). Section 130 of the Act mandated a Comprehensive Needs Study to assist individuals with significant disabilities who "cannot reasonably be expected to be rehabilitated for employment but for whom a program of rehabilitation could improve their ability to live independently or function normally within their family and community" (Public Law 93-112, p. 374). President Nixon’s administration authorized the implementation of a comprehensive needs study to determine the rehabilitation needs of those with significant disabilities. Five independent living rehabilitation projects were established (Seattle, New York, Salt Lake City, San Antonio, and Berkley) that adequately demonstrated the need for such programs (Rubin & Roessler, 1995).

Research conducted under the 1973 Act suggested that independent living does not have to be a separate system. Independent living programs can function as a complementary component of the vocational rehabilitation service delivery system.

The Rehabilitation Comprehensive Services and Developmental Disabilities Amendments of 1978 (Public Law 95-602) amended the 1973 Act. The amendments further strengthened the independent living movement. Title VII, Part A of the Act mandated that State Rehabilitation Agencies administer the federal rehabilitation program and authorized them to contract with other agencies to provide comprehensive services. Independent living services were defined to include any of the following:

- counseling services including psychological, psychotherapeutic and related services,
- accessible and modified housing,
- appropriate job placement services.
transit, attendant care, physical rehabilitation, therapeutic treatment, needed prosthesis and other appliances and devices, health maintenance, recreational activities, services for children of preschool age; including physical therapy, development of language and communication skills, and child development services, and appropriate preventive services to decrease the needs of individuals assisted under the program for similar services in the future.

Public Law 95-602, p. 2996

Title VII, Part B authorized the Commissioner of the Rehabilitation Services Administration to make grants to state agencies having approved independent living plans and to establish and operate independent living centers offering services such as:

intake counseling and peer counseling, referral, attendant care, programs for the blind and deaf, advocacy regarding legal and economic rights and benefits, housing and transportation referral and assistance, community group living arrangements, independent living skills, training with maintenance of equipment, individual/group social and recreational activities, job seeking skills and placement counseling, and assistance of substantial benefit in promoting independence, productivity, and equality of life of persons with disabilities.

Title VII, Part B also states that persons with disabilities have significant involvement in policy, direction, and management of such centers.

Title VII, Part C authorized state agencies to provide independent living services to older blind individuals (55 years and older) whose visual impairment is so severe as to make gainful employment extremely difficult, but for whom independent living goals are feasible. Services include:

outreach, visual screening, surgical and therapeutic treatment to prevent, correct, or modify
disabling eye condition,
- eye glasses and visual aids,
- Braille instruction and reader services, and
- mobility training, guide services, and transportation.

Independent living provisions realistically addressed the long ignored needs of individuals with significant disabilities. The movement legitimized "non-vocational" objectives and became a viable alternative to "employability" for those with significant disabilities in the rehabilitative process (Kundu & Schiro-Geist, 2006; Wright, 1980).

The Rehabilitation Act was further amended in 1984. These amendments mandated that the states establish Statewide Independent Living Councils (SILCs) for the purpose of providing guidance for the development and expansion of independent living programs. The Council members, who are appointed by the governor in most states, represent the special interests of state agencies, local agencies, persons with disabilities, parents and guardians of individuals with disabilities, directors of CILs, private businesses, and other appropriate individuals or organizations. The majority of the Council membership, i.e., at least 51%, must be individuals with disabilities, their parents or guardians (Jones, 1986).

The Rehabilitation Act Amendments of 1992 expanded the CILs' role and responsibilities. The CIL became an equal partner with each state's vocational rehabilitation agency in the independent living process. The Statewide Independent Living Councils were given added responsibility to assist in the development of the state independent living plan for the state vocational rehabilitation agency and to oversee its implementation (Richard, 2000).

The effectiveness of the legislation discussed above was later strengthened by the passage of the Americans with Disabilities Act (ADA) of 1990. This civil rights act rekindled the hope of people with disabilities to have the opportunity to participate in their communities and become fully functioning members of society. Advocates of independent living used the ADA as a platform to translate the act's empowering mandates into integration, independence, and productivity for those with disabilities (Kennedy, 1992).

**CENTERS FOR INDEPENDENT LIVING**

The independent living movement, which grew out of the recognized needs of persons with disabilities to rise above the boundaries of the traditional professional dominated model of service delivery, rallied around the slogan "nothing about us without us." It enabled disability rights advocates and
consumers to demand respect from well-qualified service providers who often made decisions without client involvement (Smith, Smith, King, Frieden, & Richards, 1993). By the mid-1990s, the consumer driven approaches permeated all strata of the traditional rehabilitation service delivery system. The CILs are another direct outcome of the disability rights activism. The CILs release the full potential of those with disabilities by promoting greater choice and autonomy (O'Shea & Kennelly, 1996). The consensus was on the involvement of persons with disabilities in decision-making related to all aspects of life because disability was not the concern of a special group but an experience of day-to-day living (Martinez, 2003).

Two of the driving forces of the CILs are the concepts of independence and dependence. Dependence is not always degrading and undesirable. Some dependency needs, whether one has a disability or not, apply through the life span. It is important, however, to learn how and when to ask for help or exhibit dependence. Similarly, people with disabilities need to know when independence is appropriate. Since human beings do not function in a vacuum, learning to value dependency that serves important social and economic purposes promotes healthy social interaction. For example, a person should be able to rely on others, to ask for and accept assistance, and to delegate responsibility. "Dependence as a value ought to be held in the same high regard as independence" (Wright, 1983, p. 409).

A Center for Independent Living is neither a residential nor a transitional facility. These CILs are consumer controlled, community based, cross disability, nonresidential private nonprofit agencies designed and operated within a local community by individuals with disabilities and provide an array of independent living services. A CIL is usually a facility that coordinates the efforts of professionals, persons with disabilities, volunteers, and interested entities to enable independent living and community integration for those with significant disabilities. The initial cornerstone of a CIL was service and advocacy (Wright, 1980). Because the initial focus of the CIL was on people with blindness or orthopedic impairment, the constituents were relatively young and resided in university settings. The efficacy of the independent living philosophy gradually spread among people with other disabilities and the heterogeneity of the clientele increased tremendously (Nosek, 1997). Over the past two and a half decades, 336 consumer-controlled CILs were established nationwide with approximately 253 satellite locations (Seekins, Enders, & Innes, 1999). Currently, there are about 723 CILs in the country providing services to a diverse array of individuals with disabilities (Independent Living Research Utilization [ILRU], 2007a).
The CILs offer a comfortable atmosphere for people with disabilities to determine their goals, to choose the types of services, and the provider of needed services. The representatives on CILs governing boards are primarily people with disabilities in an attempt to turn the managerial power over to the consumers. The independent living concept is accomplished utilizing three factors: (a) community option development, (b) consumer services, and (c) management. Community option development can be promoted via public awareness, technical assistance, and advocacy. It can assist the consumer in becoming more self-sufficient and less dependent on the CIL (Budde & Bachelder, 1986).

These CILs have been successful in replacing expensive medical and vocational services with low cost consumer services. Consumer services include peer counseling, independent living skills training, attendant care, advocacy, and information and referral (Budde & Bachelder, 1986; ILRU, 2007b). Counseling services provided by a nonprofessional, or peer counselor, especially one who is facing the same challenges as the consumer, increase understanding and provide a wellness model (Carter, 2000). Attendant care or Personal Assistance Services (PAS) provide the support and assistance a person may need to attain the optimal level of independence at home, school, work, and in society. Such services may include sign language interpretation, housing assistance, transportation, personal care management, employment assistance, help with activities of daily living, and non-medical assistance such as changing a urinary catheter. The key concept behind PAS is consumer control and prevention. It is strongly believed that persons with disabilities can safely deliver attendant care with some training from the consumer requiring those services (Smith et al., 1993).

Advocacy is a necessary skill to help oneself achieve independence. It includes the actions taken by individuals on behalf of one or more persons to ensure their rights and interests. Advocacy can be provided in the areas of employment, transportation, disability policy, housing, public access, health care, education, insurance issues, telecommunication, and vocational rehabilitation (White, Nary, & Froelich, n.d.; Wright, 1980). Information and referral services are geared toward educating individuals on all aspects of a disability, their civil rights, and available community resources.

The third component behind the success of a CIL is sound management with substantial consumer involvement in planning, implementation, and evaluation stages. The centers typically hire administrators and staff with disabilities. The consumer driven approach acts as a catalyst in promoting a community environment that provides support and encouragement for those with disabilities (Budde & Bachelder, 1986).

Though the numbers of CILs have increased substantially, rural residents in
40% of the nation's counties do not have access to independent living services. Annually, the existing CILs provide direct services to 212,000 individuals living in 1,896 (60%) of American counties. The median budget of a CIL is $328,000 and average is $530,000, with a lower limit of $55,000. However, typically $200,000 is required to operate an entire CIL. It has been determined that an additional $71.5 million is required to establish 218 more CILs to address the independent living services needed by Americans with disabilities (The Rehabilitation Research and Training Center on Rural Rehabilitation Services, 1999).

The needs of people from diverse cultural backgrounds remain largely unmet. The challenges facing Independent Living Centers in meeting these needs are language barriers, lack of cultural competency among service providers, under representation of ethnic minorities on CIL staff, and inadequate outreach efforts directed at potential consumers. A large portion of the US population is foreign born, which may require CIL staff to have knowledge of Immigration and Naturalization Service rules and regulations. Hiring of staff with diverse ethnic and linguistic backgrounds facilitates a modification of the independent living philosophy to make it inclusive (Bradley, 2000).

**EVALUATION OF INDEPENDENT LIVING**

The moral responsibility of society is to provide individuals with disabilities the support needed to access educational systems and participate in the labor force. The implementation of independence requires considerable effort and finances, and the financial return may not be encouraging for those who measure improvement in terms of dollars. However, when does the value of equity and justice outweigh efficiency and utilitarianism? The success of the movement will largely depend on the extent to which society is willing to sacrifice overall efficiency and assist those with disabilities to work and live an autonomous life (O’Shea & Kennelly, 1996).

Radical individualism, the cornerstone of a modern market economy, thrives on the assumption that a person maximizes his/her ability by choosing the best available alternatives and by operating as an autonomous unit. The concept works best when an individual does not encounter any hindrance in the decision making process. Consumer sovereignty is often assumed in interpreting rational economic behavior. Since economic choice has always
been limited for those with disabilities, equalization of resources may not be the proper solution to the question of appropriate financial support for this population. Equalization of choices will necessitate prudent allocation of resources to alleviate the affects of the prior disadvantaged status. The efficacy of CILs should be judged by their ability to respond to the diverse capabilities of people with disabilities requiring accommodations to reach their full potential (O’Shea & Kennelly, 1996).

Increased government spending on independent living programs over the past several years has resulted in the necessity to evaluate their efficacy on a continuous basis. The need to formulate and revise appropriate independent living goals and ascertain effective ways of determining their progress in meeting these goals demands increased accountability (Nosek, 1997). Progress was measured initially in terms of client-specific gains as a function of services delivered. Later, the concept of more comprehensive consumer gain regardless of services received was incorporated into the accountability process (Clowers, Haley, Unti, & Feiss, 1979; Muzzio, 1980).

Environmental and life status indicators play an important role in independent living. In a study of 111 adults with spinal cord injury, marital status, transportation barriers, and the degree of medical supervision required proved to be significant predictors of attainment of independence. The last two factors negatively impacted independent living (DeJong, Branch, & Corcoran, 1984).

McAweeney, Forchhmeimer and Tate (1996) reported that consumers with unmet needs were either those with the least or the most functional limitations. Peer recreation and peer support groups were the two most needed services. This finding was contrary to the opinion that CIL services such as transportation, personal assistance, housing, and advocacy need to be improved. Nosek (1984) studied 67 persons with orthopedic impairment to assess the affects of personality factors and functional abilities on the achievement of independent living goals. It was concluded that participants with more psychological independence had less restrictive living arrangements, spent less time in rehabilitation facilities, and encountered fewer communication problems. A high level of social independence was directly proportional to self-sufficiency, assertiveness, education, earning power, and marital status. Functional abilities did not seem to have any affect on the level of independence.

A society that offers fewer choices fosters greater inequity. Economists may argue that an equitable distribution of resources to informed individuals making selections from an equal number of choices is too expensive. Society has a responsibility to persons with disabilities to prevent relegating them to second-class citizen status. It is important that independent living programs be
established, operated, and evaluated in a sensitive manner (Le Grand, 1991).

**NATIONAL COUNCIL ON INDEPENDENT LIVING**

This national membership organization was established in 1982 for the purpose of representing CILs and individuals with disabilities. The founders were a small group of renowned disability rights activities, e.g., Mr. Max Starkloff, Ms. Marca Bristo, Mr. Charlie Carr, and Dr. Judy Heumann. The efforts of NCIL, a non-profit entity, have been commendable in standardizing requirements for consumer control in management and delivery of services provided by CILs. Largely supported by an extensive network of committed and dedicated volunteers from CILs and related organizations, in 1992 NCIL opened its national office in Arlington, VA. Later the office moved to 1710 Rhode Island Ave, NW, 5th Floor, Washington D.C. 22036. The establishment of an official domicile facilitated its efforts to eliminate disability-related discrimination and unequal treatment. The organization is considered a strong voice for independent living and consumer-driven advocacy for people with disabilities around the country. NCIL offers internships to policy-oriented individuals to assist the Director of Advocacy and Public Policy in monitoring laws, policies, and regulations related to the organization’s priorities. This unpaid internship also offers opportunities such as establishing legislative relationships with Capitol Hill, writing action alerts and parts of advocacy newsletters, and regularly tracking key issues (NCIL, 2006).

**INTERNATIONAL PERSPECTIVE**

On a global scale, independent living is a social movement geared to promoting self-organization, civil rights, self-help, and the enhancement of quality of life for millions of people with disabilities. The primary ingredient of the movement is the sense of commonality among its constituents. Providing benefits and services is considered a prelude to the establishment of independent living in the industrialized world. Services can be defined as
economic support, vocational rehabilitation, education, and formulation of
government organizations to address disability related issues.

The importance of providing these basic services was first recognized in the
1960s in Latin American, Spanish, and Portuguese speaking Europe, Africa,
and Asia. Due to financial and infra structural constraints, the benefits of
disability awareness and rehabilitation services could reach only a very small
number of people in these countries (Independent Living Research Utilization,
1999).

In 1962, French students, who wanted more control in obtaining the
services they needed to become self-sufficient, formed the Group for
Integration of Physically Disabled Persons (GIHP). France ultimately became
the leader in providing peer support, one of the core concepts of independent
living services. Between 1970 and 1980, self-help organizations were
established in South Africa and Latin America. In the following decade,
countries like the United Kingdom, Canada, Germany, Ireland, Austria, The
Netherlands, and Uganda followed suit (Independent Living Research
Utilization, 1999).

A study conducted to evaluate the INCARE personal assistance program in
Ireland found that Irish people with disabilities have little input in setting the
public policy that impacts their lives. It was found that the primary reason was
that they have little or no representation in the decision making process.
Services are planned, delivered, and evaluated without any consumer
involvement. To achieve self-direction and obtain adequate services to meet
their needs, individuals with disabilities are forced to employ a personal
assistant (McGettrick, 1994).

The civil rights movement among African Americans led world leaders to
recognize the importance of legislative action to promote equal opportunities
for those with disabilities. In 1969, Rehabilitation International created the
universal symbol of accessibility. The principal purpose in creating the symbol
was to emphasize the need for promoting architectural accessibility in all facets
of society. In 1981, the International Year for Disabled Persons provided an
impetus to the disability rights and independent living movements and
emphasized the need for self-determination among those with disabilities.
National organizations were established in Sri Lanka, Uganda, Jamaica, China,
the United Kingdom, South Africa, Brazil, Fiji, Thailand, and the Philippines
(Independent Living Research Utilization, 1999).

In 1980, white South Africans participated in the Rehabilitation
International Congress. Upon their return home as newly indoctrinated
members of the independent living community, they found that their black
counterparts had been practicing the philosophy for years as part of the anti-
apartheid campaign. The European Network on Independent Living (ENIL)
was established in 1990 to lobby for personal assistance services and to educate politicians about the independent living philosophy.

In 1992, the first CIL was founded in Ireland to implement the INCARE program for developing a consumer controlled personal assistance service (O'Shea & Kennelly, 1996). Gradually, the movement gained support in Asia, especially in Japan, with the active support of European and US disability rights leaders.

The United Nations Convention on the Rights of Persons with Disabilities was adopted on December 13, 2006 during the sixty-first session of the General Assembly. It was designed to spell out in detail the rights of persons with disabilities and establish a code of implementation. This was the result of the realization that a change of perception was necessary to improve integration and advancement of persons with disabilities in their communities by combating stereotypes/prejudices and promoting public awareness of the capabilities of the target population. The importance of freedom of choice and right to independent decision making was also emphasized (United Nations, 2006).

The international movement has had many positive outcomes. It has increased the incomes of people with disabilities, facilitated the use of assistive devices and personal care assistance, promoted the accountability of the funds allocated for services, and integrated people with disabilities into their communities. This success has not been without its detractors. The concept of independence has been widely criticized by several developing countries as a culturally loaded term. A direct result of this criticism brought about the coining of a new term "inter-dependence" to express the meaning of independent living more comprehensively. Nevertheless, this new term cannot dislodge the deep-rooted belief in the doctrine of independent living that has kept the dream of self-organization, self-determination, empowerment, and self-direction alive for many with disabilities around the world (Independent Living Research Utilization, 1999).

REFERENCES


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