

The Independent Living Movement and People with Psychiatric Disabilities: Searching for Common Ground

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Introduction

In this article, the authors draw upon over 50 years' collective experience as administrators, managers, policy makers, advocates, activists, and service providers to people with psychiatric disabilities. Their work is informed by values and principles arising from their personal experiences of being treated in public and private psychiatric hospitals, their own recovery journeys, and their ongoing work in self-help and empowerment with people with psychiatric disabilities.

The authors explore the relationship between the larger disability rights movement and the movement for the rights of people with psychiatric disabilities, as well as the largely unrealized potential for Independent Living Centers (ILCs) to assist people with psychiatric disabilities. Independent Living Centers are local non-profit, consumer-controlled, community-based organizations that provide information, services and advocacy by and for people with disabilities, with the goal of helping people with disabilities to achieve maximum independence and self-determination (Independent Living Centers USA, 2003). ILCs offer a clear alternative to impairment-based treatment systems for people with a range of disabilities, and would seem like an ideal resource for people with psychiatric disabilities who are trying to throw off their "mental patient" roles and integrate back into their communities. While data are not collected in a manner that provides precise information about how many people with psychiatric disabilities currently use ILC services, the authors' work to bridge the gap between these two movements, described below, leads them to believe that people with psychiatric disabilities are seriously under-served by ILCs. This article will address the possible reasons for this situation, and will make recommendations to help both ILCs and people with psychiatric disabilities work together more successfully.

People with psychiatric disabilities are the single largest disability group in the United States (WHO, 1999), yet they lag behind other disability groups in becoming an effective force in the political

arena. Although activists in the psychiatric disability movement share similar agendas with people with cognitive, sensory and physical disabilities, they have only recently started to become involved in cross-disability alliances and coalitions working on common goals. Even within the larger disability rights movement, attitudes about people with psychiatric disabilities continue to remain mired in misconceptions and myths perpetuated by the media and driven by a paternalistic medical model. And although people with psychiatric disabilities have the same desire as people with other disabilities to fully participate in the communities in which they choose to live, the lack of significant public contact with this group allows the myths to continue, and the potential for societal change to be unrealized. A meta-analysis of the research on stigma (Corrigan & Penn, 1999), shows that of three interventions used to try to reduce stigma, (1) challenging mis-information and stereotypes, (2) education, and (3) contact with members of the stigmatized group, the third is clearly the most effective. Yet people with psychiatric disabilities, even those living outside of institutions, remain an invisible minority to most Americans.

In this article, the authors describe what they have learned from conducting interviews with executive directors and staff of Independent Living Centers, from facilitating day-long dialogues between ILC staff and people with psychiatric disabilities in which both groups discussed their needs, goals, experiences and thoughts about how they might more effectively work together, and from the response to a presentation of their work at the National Independent Living Council annual conference in 2002. The workshop, which was targeted to ILC administrators and staff, was enthusiastically received by participants who signed up to receive information updates on further educational and training opportunities.

History of Disability Activism in the United States

While modern disability rights movements in the United States are generally understood to have started in the 1960s and 70s, (Pfeiffer, 2003;

McDonald & Oxford, 1998), the history of disability activism can be traced back to the 1850s, when deaf people organized local groups to advocate for their interests (Mountain State Centers for Independent Living, 2000). During the 1930s, an era of social activism on many fronts, people with physical disabilities, including disabled World War I veterans, were among those who organized to demand their rights. Historian Paul Longmore (2000) cites the establishment of the League of the Physically Handicapped in New York City in 1935, and a sit-down strike by blind employees of a Pittsburgh sheltered workshop in 1937, as forgotten examples of early disability activism.

The League of the Physically Handicapped, which had several hundred members at its peak, held a sit-in at the local office of the Emergency Relief Bureau to protest the Bureau's refusal to refer people with disabilities to the Works Progress Administration for employment. According to Longmore (2000), the group's "...actions included picket lines and demonstrations and league members spoke to labor unions and progressive organizations in an attempt to educate these groups on disability issues. Like many groups struggling for economic and social justice the League of the Physically Handicapped was accused of being "reds." Blind workers at sheltered workshops made several unsuccessful attempts to win collective bargaining rights during the 1930s; the sit-down strike in Pittsburgh was one of a number of local actions. Longmore (2000) notes that "the local press seemed more impressed with the 'oddity' of the event than with the fact that a group of disabled workers were angry enough to organize a militant rank and file job action in their place of employment."

While militancy ended with the start of World War II, disability organizing continued. The National Federation of the Blind and the American Federation of the Physically Handicapped were organized in the early 1940s. In aftermath of World War II, returning disabled veterans founded the Paralyzed Veterans of America. (Mountain State Centers for Independent Living, 2000).

The next phase of physical disability activism had its roots on university campuses. David Pfeiffer (2003) cites the early example of Ted Nugent, who

had dormitories at the University of Illinois at Champaign-Urbana made accessible for mobility-impaired veterans in 1946. In 1962, the University's disabled students program became a pioneer in facilitating community living for people with physical disabilities, when four severely disabled students were transferred from a nursing home to a modified home closer to campus (DeJong, 1979). Edward Roberts, a wheelchair user, became the first severely physically disabled student to live on campus at the University of California at Berkeley; the *Berkeley Gazette* announced his arrival in 1963 with the headline "Helpless cripple attends classes at UC" (O'Hara, 2000). Roberts, who went on to become the first person with a disability to serve as Director of the California Department of Rehabilitation, organized other students who used wheelchairs on the Berkeley campus; the group took the name "The Rolling Quads" (Mountain State Centers for Independent Living, 2000). In 1972, he was a founder of the Center for Independence (CIL) in Berkeley, the first such organization in the country, and is seen as the primary mover behind what came to be known as the Independent Living Movement (McDonald & Oxford, 1998). The Berkeley CIL was based on three principles grounded in the daily experience of people with disabilities:

1. Those who best understand the needs of disabled people and how to meet those needs are disabled people themselves;
2. Disabled people's needs can be met most effectively by programs which provide a variety of services, rather than having to go to several different agencies for services;
3. Disabled people should be as integrated as possible into the community. (Zukas, 1979).

Independent Living: A Philosophy and a Movement

The independent living paradigm, as described by Gerben DeJong (1979), sees problems or "deficiencies" in society's response to people with disabilities, rather than in the individual with a disability. The IL philosophy emerged in response to the rehabilitation model, which disability rights activists saw as dependency-inducing, as well as to other barriers in the physical and social environment. To cope with social and environmental barriers, the IL philosophy holds that the disabled person must shed

the patient role in order to achieve independence. Advocacy, peer counseling, self-help, consumer control, and barrier removal are the trademarks of the IL paradigm. (Brown, 2000; McDonald & Oxford, 1998).

The IL movement stresses that social and attitudinal barriers, not disabling conditions, are the primary problems facing people with disabilities.

Beginning in the late 1960s, several pieces of federal legislation were passed which had a positive impact on the lives of people with disabilities and on the IL movement. In 1968, the Architectural Barriers Act was passed, requiring the elimination architectural barriers in all federally owned or leased buildings. The 1970 Urban Mass Transit Act required that all new purchases of mass transit vehicles be equipped with wheelchair lifts (Shreve, 1982). In 1973, Congress passed the Rehabilitation Act, a landmark piece of legislation which gave rise to a series of new initiatives to benefit the nation's most severely disabled citizens. A key provision of the Act is Section 504, which prohibits discrimination against "otherwise qualified handicapped individuals under any program or activity receiving Federal financial assistance." Section 504 suddenly opened a wide array of opportunities for people with disabilities in employment, housing, and education (De Jong, 1979). The 1973 Rehabilitation Act included several other important provisions: it mandated that people with the most serious disabilities receive the highest priority for services under the Act, and created affirmative action programs for employment of people with disabilities in the federal government and by organizations receiving federal contracts.

Federal funding for IL services began in 1978, authorized by amendments to the Rehabilitation Act of 1973 which created Title VII - "Comprehensive Services for Independent Living." The law established a four-part program: (1) an IL services program to be administered by the state vocational rehabilitation agencies; (2) a grant program for IL centers; (3) an IL program for older blind persons; and (4) a protection and advocacy program to guard the rights of severely disabled persons (De Jong, 1979). This legislation was instrumental in the establishment of funded IL Centers in every state. In 1986, further amendments

to the Rehabilitation Act required IL Centers to have a majority of people with disabilities on their boards of directors, a provision which ensured that IL Centers were consumer-run (Shreve, 1982). In the 1990s, this provision was expanded to include IL Center management as well (Brown, 2000).

During the 1980s, the IL movement continued to expand. The National Council on Independent Living (NCIL), was founded in 1982 by Independent Living Center directors who felt that the federal government was not paying sufficient attention to the views of people with disabilities. (NCIL website, undated). During the late 1980s, Marca Bristo, executive director of Access Living in Chicago, was elected president of NCIL. She led the fight against President Ronald Reagan's unsuccessful attempt to overturn Section 504 of the Rehabilitation Act of 1973. Ironically, Reagan also appointed disability activist Justin Dart as Commissioner of the Rehabilitation Services Administration (RSA) (Brown, 2000). Dart was later fired by the Reagan Administration after testifying before Congress that the RSA was "a vast, inflexible federal system which, like the society it represents, still contains a significant portion of individuals who have not yet overcome obsolete, paternalistic attitudes about disability." Dart continued to be a key leader in the national disability rights movement, and spearheaded the fight to pass the Americans with Disabilities Act. In 1998, President Bill Clinton awarded him the Presidential Medal of Freedom, the nation's highest civilian award (Fay & Pelka, 2002).

The most important modern legislation affecting people with disabilities, the Americans with Disabilities Act of 1990 (ADA), was passed largely by the efforts of disability rights organizations across the country. According to the United States Department of Justice (2003), "The Americans with Disabilities Act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications." Disability rights organizations lobbied hard for passage of the ADA, and its passage

resulted in celebration and raised expectations in the IL Movement.

While there have been many successes in implementing the ADA, a number of Supreme Court rulings over the 13 years since the law's passage have weakened many of its provisions. In 2001, for example, the Court held that state and municipal governments are not bound by all of the employment provisions of the ADA (Ward, 2003). Lower court decisions have also worked to undermine the ADA. A study by the American Bar Association found that employers prevailed in more than 94 percent of the ADA employment-related cases decided in 2003 in federal courts; the study concluded that ADA standards are interpreted by the courts in ways that "still create obstacles for plaintiffs to overcome" (Ward, 2003). A coalition of disability rights organizations, believing that the law's protections are under serious threat, formed ADA Watch in 2002 to monitor implementation of the ADA and to disseminate information about threats to the Act. The ADA covers people with psychiatric disabilities, too, so an alliance between the physical and psychiatric disability movements to protect the ADA would be beneficial to both groups.

The Independent Living Movement and the Ex-patients' Movement: Similarities and Differences

The Independent Living Movement and the rights movement of people with psychiatric disabilities have much in common; they are based on similar goals, such as the right to self-definition and self-determination, removing barriers to social integration, and gaining and retaining rights. Both movements operate on the principle that the problem lies not in individuals with disabling conditions, but with a system which has made them dependent on medical professionals and denied them full access to employment, housing, and other opportunities. Both see solutions to their group's concerns in political activism, self-help, and equality under the law (De Jong, 1979; Chamberlin, 1990). Both movements drew inspiration from the civil rights movement of black people in the 1960s (Mc Donald & Oxford, 1998; Kolinowski & Penney, 1998). But these movements evolved separately in the United States, have taken somewhat different paths, and have had

differing levels of success.

The rights movement of people with psychiatric disabilities, also known as the ex-patients' movement, has roots in 19th century social reform movements and the work of individual ex-patients struggling for justice in that era. The modern ex-patients' movement began in earnest in the 1970s with little awareness of those historical roots. What was then often termed the Mental Patients' Liberation Movement took its inspiration from other contemporary collective movements of disenfranchised peoples, including the African-American civil rights movement and the women's movement. Like these movements, the ex-patients' movement was concerned with human and civil rights, with prejudice and discrimination faced by its members, and with developing a future in which the larger society would recognize their full humanity (Blanch, Penney & Knight, 1994).

The early ex-patients' movement was heavily influenced by feminist thinking; the movement developed an analysis of the mental health service delivery system as a top-down, patriarchal system that isolated diagnosed individuals and deprived them of power. Women have played a pivotal role in the growth and development of the ex-patients' movement over the last 30 years. Many of the early leaders, theorists, writers and activists were women, many of them influenced by feminist thinking. Since women are more likely than men to be psychiatrically diagnosed and treated with psychotropic drugs (Eichler & Parron, 1987), it is perhaps not surprising that women have always been active in the movement. What is somewhat surprising is that, unlike the civil rights movement or the anti-war movement, women have not been only the workhorses of the ex-patients' movement, but prominent leaders as well.

Pioneering activists recognized that the medical model of mental illness, a model based on the patriarchal view that professional "experts" should control the treatment of people with psychiatric labels, was a primary source of their disenfranchisement. As Susan Stefan (1996) has pointed out, "a disease model for emotional distress may carry hidden problems for women and minorities and others whose distress and discontent may be due to their social circumstances, but which the disease model places

squarely on deficits in their biological makeup.”

In an attempt to come to terms with the effect of the medical model on their lives, ex-patient activists embraced the process of consciousness-raising as a tool for helping to understand their experiences in a social and political context (Chamberlin, 1990). Consciousness-raising is a group process in which people with some form of commonality share and explore their experiences in order to draw connections between the personal and the political. As practiced within the women’s movement, consciousness-raising helped women recognize that problems around issues such as relationships, sexuality, and feelings of inadequacy were not so much individual problems as they were manifestations of society’s systemic oppression of women.

In a parallel way, the practice of consciousness-raising within the ex-patients’ movement helped individuals realize that many of the difficulties they encountered in the mental health system were not individual problems related to their diagnoses, but the result of patterns of discrimination and oppression. Ex-patients came to learn that their feelings of isolation, inadequacy, and powerlessness were the result of real practices within the mental health system and real discrimination in the community, not by-products of their “illnesses.” They came to see that the public at large held a set of negative assumptions about mental patients: “that they were incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, likely to be violent or irrational” (Chamberlin, 1990). Consciousness-raising was also instrumental in helping ex-patients recognize their own internalized stigma, their unconscious agreement with society’s negative stereotypes of mental patients, and in developing new, more empowering beliefs about their abilities.

As the movement developed, it maintained many of the values and principles of other collective movements of disenfranchised groups. The movement worked (and continues to work) for social, political and legal equality with other citizens, for the right to self-definition and self-determination, and for person-centered alternatives to the disempowering clinical practices encountered in the mental health system. As Judi Chamberlin (1991) recounts:

groups were united by certain rules and principles: mental health terminology was considered suspect; attitudes that limited opportunities for mental patients were to be discouraged and changed; and members’ feelings - particularly feelings of anger toward the mental health system - were considered real and legitimate, not “symptoms of illness.”

Over the past three decades, the ex-patients’ movement has gone through cycles in which its influence on mental health policy has waxed and waned. Once a generally discounted fringe group, the movement gradually gained acceptance within the mental health field during the mid-1980s- through the mid-1990s, only to find itself once again marginalized as the political climate grew more conservative. The literature of the movement reflects the process of growth and development of a coherent philosophy based on humanistic values. Judi Chamberlin (1994) argues that the mental health system is driven by paternalism, which she defines as “the idea that one group (the one in power) “knows” what is best for another group (which lacks power). The history of our civilization is, in part, the struggle against paternalism and for self-determination.”

Among the concepts frequently identified as valuable and desirable in the ex-patient literature are empowerment, choice, healing and recovery (Fisher, 1994; Bassman, 2000); these concepts are seen as closely linked to one another. Self-help and mutual support are seen as key ingredients of a process by which people may promote their own healing (Chamberlin, 1984; Fisher, 1994).

From the 1970s through the 1990s, the ex-patients’ movement and the IL movement developed separately, despite their similarities in philosophy and purpose. The reasons for this are complex. A major factor is involuntary commitment laws, which are applied only to people with psychiatric disabilities, which legally allow people to be removed from their communities and incarcerated against their will in psychiatric institutions. Involuntary commitment laws are still on the books in every state; during the 1990s, many states passed laws allowing for involuntary outpatient commitment as well. So while the physical disabilities community won many legal rights (rights that should also have applied to people with psychiatric disabilities) during this period, people with

psychiatric disabilities actually saw their rights eroded.

Another factor in the development of two separate movements may also be the fact that the mental health system has kept its users isolated from the community at large. While fewer people spend their entire adult lives in psychiatric institutions than a generation ago, they continue to be segregated in adult homes, community residences, and day treatment programs, rarely interacting with the general community or with people with other disabilities. This isolation has helped develop a subculture in which many people with psychiatric disabilities accept themselves as part of a marginalized group of second-class citizens. People in this situation tend to think of themselves as “mental patients,” with all the emotional baggage that implies, rather than as citizens with psychiatric disabilities.

The federal funding for ILCs which began in 1978 cannot be discounted as an important reason for the disparate levels of success between the physical disabilities movement and the psychiatric ex-patient movement. ILCs provided a base for people with physical disabilities in many communities, providing not only services, but a place where people could become involved in issue-oriented activism. While some states and localities have funded peer support centers for people with psychiatric disabilities, there is not a nation-wide, federally funded base of such programs for the ex-patient community. And while ILCs who receive federal funding are mandated to provide services to all disability groups, people with psychiatric disabilities were largely absent from ILCs from the beginning.

Another potential reason for the separation between the two movements may be something that Nicolas Steenhout (2003), a former IL Center director, has observed in his work: While all Centers for Independent Living claim to be cross-disability, too often I see problems with the application of that concept... I think part of the problem is that we lack sufficient awareness of other disabilities. I've heard people in the independent living movement make light of the needs of folks with multiple chemical sensitivities, dismissing it as 'all in their heads.' We still use expressions such as 'it's crazy,' or 'she must be off her meds today'... Perhaps part of the problem is that we too easily buy into the ranking of disabilities that society seems to impose on us. Cognitive disabilities are

'worse' than physical disabilities; having cerebral palsy is 'worse' than having a spinal cord injury; having quadriplegia is 'worse' than having paraplegia; using a cane or a crutch is better than using a wheelchair, and so on.

Steenhout goes on to suggest seriously that Independent Living Center staff need disability awareness training.

The Independent Living Movement has mostly consisted of people with physical or sensory disabilities. The literature on the history of the IL Movement rarely mentions people with psychiatric disabilities; in fact, it often speaks specifically and exclusively of people with physical disabilities, and people without disabilities are usually referred to as “able-bodied” (O'Hara, 2000; Shreve, 1982). De Jong (1979) notes that “the movement has concentrated its energies on a relatively few major disability groups: those with spinal cord injury, muscular dystrophy, cerebral palsy, multiple sclerosis, and post-polio disablement,” and points out that elderly people and racial minorities are under-represented in the IL movement; he does not address the fact that people with psychiatric disabilities are also under-represented. When the IL literature does mention people with psychiatric disabilities, it is ironically often in the language of the medical model (i.e., “the mentally ill”), which the IL movement vehemently objects to when it is used to describe people with physical disabilities (McDonald & Oxford, 1998). People with psychiatric disabilities do not hold leadership positions in IL Centers, in the authors' experience, and very few are on staff at IL Centers.

While the IL Movement often overlooks people with psychiatric disabilities when defining its constituency, people with psychiatric labels have not traditionally defined themselves as “disabled,” and have only recently begun to understand that there is a natural alliance between the two groups. And ex-patients are not immune to cultural stereotypes of people with physical disabilities, and do not always take the needs of people with physical disabilities into account; the authors have sometimes heard ex-patients question why we need to have meetings in wheelchair accessible facilities, or why we need to pay for sign language interpreters. Clearly, both groups have much to learn about each other.

Discussion

While people with physical and sensory disabilities have historically been discouraged from trying to break through externally imposed limitations, the stereotypes and paternalistic attitudes that have marginalized them are beginning to succumb to the power and influence of daily exposure. Since the 1970s, federal legislation has made many more places accessible to people with physical disabilities, so the public has become used to seeing disabled people where they work, where they shop, on busses, in movie theaters, and in a host of daily situations. Unfortunately, people with psychiatric disabilities continue to face daunting obstacles to community inclusion, and have not received much benefit from disability rights legislation.

People with psychiatric disabilities are still fighting many of the fights that people with physical disabilities won years ago, including the right to self-definition and self-determination. For example, mental health professionals still routinely refer to people by their diagnoses, (i.e., "The borderline on Ward 5"), rather than using people-first language. A person with a psychiatric disability often finds that others interpret her behavior through the lens of symptomatology; so a person with a psychiatric disability isn't just sad, or upset, or having a bad day - she is frequently viewed as "symptomatic" for expressing the normal range of human emotions. Too often, mental health professionals and family members claim to speak on behalf of people with psychiatric disabilities; while people in these groups may be strong and valued allies, they cannot speak on behalf of people with disabilities.

Who has a psychiatric disability, and how is it defined? There are many hypotheses and unproven theories which purport to give definitive answers about the causes and nature of "mental illness." The medical model, which is embraced by most mental health professionals and systems, states that the causes are biochemical, even though there is no physical marker for any psychiatric diagnosis. In recent years, there has been much research on the role that childhood sexual assault, physical abuse, and other traumas play in the development of extreme mental and emotional states (Beck and VanderKolk, 1987; Breyer, et al, 1987; Crane, et al, 1988). Some theorists see

causation in poverty, poor living environments, stress, and other living conditions faced by poor people on a daily basis (Rosenhan, 1973; Sarbin and Mancuso, 1980; Zinman, Harp and Budd, 1981; Mancuso, 1996.) Recovery from a diagnosis of schizophrenia, long believed impossible by the psychiatric establishment, has been documented in a number of replicable research studies (Harrison, Hopper, et al, 2001; Harding, et al, 1987; Tsuang, et al, 1979).

But do people with psychiatric diagnoses have "disabilities" in the sense understood by people with physical disabilities? The Americans with Disabilities Act of 1990 defines "disability" as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment." This definition is explicitly inclusive of people with psychiatric disabilities. Confusion may arise in some people's minds because many people with psychiatric histories are only periodically disabled by their condition. Another source of confusion is that the two movements do not use the same terminology. Language about "recovery" (a term borrowed from the substance abuse field) is rife within the mental health field, although it is a term many ex-patients are not comfortable with. "Recovery" is not a term used by people with physical disabilities, who don't see their conditions as something to "recover" from. Rather, they are looking for society to adapt to their needs by establishing accessibility, the removal of physical, social, and legal barriers, and providing support. Differences in terminology and culture between people with physical disabilities and people with psychiatric disabilities need to be explored, discussed, and understood, so that the two group's joint goals and objectives will not be confounded by a lack of clarity.

As the authors discovered in their work with Independent Living Centers, even people with physical disabilities seem to look at people with psychiatric disabilities almost exclusively through a medical model lens. In our day-long dialogues in which Independent Living Center staff and people with psychiatric disabilities discussed their experiences and knowledge of each other, significant gaps in information and strategies were apparent. Some ILCs said they

provided services to many people with psychiatric disabilities; others said they did not know how to respond to people with psychiatric disabilities who wanted ILC services, or were uncomfortable serving them. While Independent Living Center staff varied widely in their familiarity with peer-run alternatives for people with psychiatric disabilities, most relied exclusively on medical model explanations and interventions when a person with a psychiatric label sought help or appeared to be in crisis.

Some common questions and concerns from ILC administrators and staff included: What if someone we are seeing wants us to help him stop taking psychiatric drugs? What if a person with a psychiatric disability comes in and is angry and upset and looks like he is about to lose control? When I am having problems, I recognize the physical signs; does a person with a psychiatric disability know when she is getting symptomatic and needs more medication? How do we communicate with someone who we know is out of touch with reality?

These questions reflect not only a lack of familiarity with the wide range of people with psychiatric disabilities and with the culture of the ex-patients movement, but also the profound influence that the medical model exerts on society's perception of people with psychiatric histories. Even though people active in the Independent Living movement have rejected the medical model's stereotypes of themselves, many have not applied this principle to people with psychiatric histories. Like the proverbial man whose only tool is a hammer, those who see people with psychiatric labels only through the medical model lens believe that all problems can be solved with the right nails: psychiatric drugs. Many ILC staff told the authors that if a person with a psychiatric disability was angry or upset, they saw them as unpredictable and perhaps violent, with the only possible intervention being to call the police or the crisis unit. Just as familiarity with groups of marginalized people diminishes stereotypes and discrimination, the lack of contact with people with psychiatric disabilities sustains society's fearful images of madness. If people with psychiatric disabilities are to feel welcome and included at Independent Living Centers, those in the IL movement will need to spend time exploring their commonalities with people with

psychiatric disabilities.

A truly cross-disability Independent Living Center would learn to see people with psychiatric disabilities not as "the mentally ill," but as fellow individuals with disabilities who have a wide range of experiences, abilities, strengths and personal resources. An inclusive disability community would develop strategies for helping all disabled people reach their full potential. People with psychiatric disabilities would be welcomed in leadership roles at IL Centers, and their perspectives and experiences would be valued.

In July 2003, The President's New Freedom Commission on Mental Health released its final report, "Achieving the Promise: Transforming the Mental Health System in America." The report identifies psychiatric problems as the single leading cause of disability, citing a 1999 World Health Organization report finding that mental illnesses account for over 25% of all disabilities across major industrialized nations. The report goes on to state that people with psychiatric disabilities have the lowest employment rate of any disability group in the United States, 33%. Clearly, this large group of people with disabilities could benefit from the community-integration orientation of Independent Living Center services. The New Freedom Commission recommends "increasing education, employment and independent living goals," so that people with psychiatric disabilities may "live independently and live productive lives." This goal owes much to the philosophy and accomplishments of the Independent Living movement. The development of mutual understanding and a strong working alliance between the IL movement and people with psychiatric disabilities would help make the Commission's goal a reality.

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