

GEOGRAPHICAL PERSPECTIVES ON DISABILITY: A SOCIO-SPATIAL ANALYSIS OF THE MENTALLY DISABLED POPULATION IN RUSSIA

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ABSTRACT: *This paper introduces a geospatial model of disability, by integrating two previous non-geographic models of disability. Using this model alongside other methodologies of “disability geography,” I strive to analyze the subjugating forces of the Russian disabled population. People of disability have long been viewed as embodiments of abnormality and rejection that had no place in the mercantilist, Soviet system. Though the fall of Communism and the materialization of democratic ideologies resulted in the relative liberation and empowerment of Russians with chronic and mental disabilities, these changes have hardly been thorough, as these groups continue to personify a marginalized role in the broader cultural, economic, and political arenas. By combining existing western thought and research in the field of disability geography with the situation in contemporary Russia, I strive to create a socio-spatial platform from which further analyses may flourish. Of particular interests are the constraining forces that continue to support disability ghettos—mostly urban areas that continue to represent the historical centralization of developmentally, physically, and psychiatrically disabled Russians. This sector of Russian society has thus far been ignored in western geographical discourse, and I see a need to supplement existing non-geographical perspectives with spatial interpretations of this particular population.*

INTRODUCTION

In recent years, geographers have made significant strides towards understanding the spatiality of disability. This research has presented disability as a characteristic of the population that inevitably leads to marginalization and spatial exclusion from otherwise normal social arenas and spaces within the built environment (Butler and Bowlby, 1997). In many ways, the recent attention to this seems inevitable, given the increasing dialogue regarding other marginalized populations. However, a simple lumping of disability in with other suppressed groups would merely prove the naïveté of such an act, and would neglect both the heterogeneity of “disability” and the impact of such a characteristic. Indeed, like other research on topics like race and gender, analyzing the marginalization of disability requires new perceptions on old topics like “the body,” “the home,” and “the workplace.” As such, a myriad of new questions arises that address the new “geography of disability.”

As many scholars note, the recentness of any attention to disability in this field reflects two important issues that are inherently presented in much of the research on disability and the landscape: first, almost none of the academics and researchers

who focus on this topic suffer (and never have suffered) from any disability that would allow them to truly understand the situation that disabled persons find themselves in (Chouinard, 2003; Golledge, 1996)¹; and second, the lack of attention to this subject is a shining example of the oppression of people with disabilities (Golledge, 1997). Of course, I am an epitome of the very homogeneity that has been critiqued; I am a white, middle-class, fully-abled male. But the subsequent analysis and interpretation of disability will hopefully not simply be written off. Much of this paper emanates from the work written by researchers who, indeed, have more experience in this field, and in many cases, personal experience with a disability.

The reason for isolating Russia within this framework is not as superficial as one might think. Although much of the motive for spotlighting Russia is my own personal interest for this country and its history, I have decided to focus on Russia’s disabled citizens primarily because little attention has been paid to their plight. While many western disability academics have spent endless hours discussing western disabled people, the very ignorance that they accuse westerners of possessing could be said about

¹These two scholars are, themselves, disabled.

their enormous lack of attention to people with disabilities in other cultures—specifically, those who are living in environments that completely lack the supports necessary for their lives to be normal. Russia is steeped with prejudicial attitudes towards people with any disability, and especially those with permanent disabilities like mental retardation, developmental disabilities, and what are often called “intellectual disabilities.” Furthermore, Russia’s formative years are still arguably upon us, and the time to make an impact is now. Instead of creating a situation like that which was forced by the Disability Rights Movement in America—goals that strive to retroactively change the populace’s attitudes—a perfect opportunity awaits interested parties to work with Russian scholars to erect an able and disabled foundation of Russia. It is my goal to bring attention to the entirely “ableist” geography of Russia that inherently rejects those citizens who do not represent the “normal” specimen, and perhaps create a foundation similar to Parr’s “new geography of mental health” (Parr, 1997).

MEDICAL AND SOCIAL MODELS

Historically, disability has existed in a strictly medical context, shaped by the impairment itself and the impact that it has on the individual. Under this medical model, disabilities were often seen as “individual medical tragedies” (Parr, 1997), which were dependent upon medical and technological advances that would assist in normalizing the disabled body. Like a sickness, the individual was blamed for such rejection of bodily standards, leaving her with indignation towards the injustice that accused her of deliberately varying from society’s norms. Until recent decades, this has been the platform upon which disabilities have been analyzed, leaving little hope to people who live with disabilities. And though the medical model did not completely reject the social and physical access that disability inherently limits, such “assistance” came in the form of suggestions that merely normalized the body—a subtle way of confirming that patient’s feelings of being outcast (Gleeson, 1999). An example of the medical model is the retroactively installed handicap entrance in the rear of a building, which was installed innocuously; yet the accessibility

that this entrance provides is undermined vis-à-vis needing to enter through the rear entrance.

A more recent interpretation of disability is sociological, and it most notably indicates a rejection of the medical model as the be-all-end-all (Dear et al., 1997). In this social model, disability is seen as an experience instead of a problem, and it becomes a social identity instead of an “objective fact of nature” (Gleeson, 1999, 20). This model has garnered wide support among disability advocates, as it becomes an empowering embodiment of disability, giving credit to disabled people for having persevered through their experiences with disabilities (Dear et al. 1997). In turn, many people who have long felt victimized now recognize the power of the social model’s ability to rid disability from the bigotry of previous conceptions of this subject. As one scholar writes:

This was the explanation I had sought for years. Suddenly what I had always known, deep down, was confirmed. It wasn’t my body that was responsible for all my difficulties, it was external factors, the barriers constructed by society in which I live. I was being disabled—my capabilities and opportunities were being restricted—by prejudice, discrimination, inaccessible environments and inadequate support. Even more important, if all the problems had been created by society, then surely society could uncreate [sic] them. Revolutionary!
--Butler and Bowlby, 1997, 412-3

In revealing this newfangled freedom that the social model entails, this account demonstrates the actual repression that disability involves. Though it suffices to say that this is an extremely optimistic viewpoint, the social model does, indeed, shed new light on scenarios that were previously deemed irreparable. Nevertheless, this model is not without flaw. Its premise is abstract, and any suggestions for change emerging from this model will require complex plans that are absent from the simplicity of the medical model. This abstractness has hindered widespread adaptation to the social model because it is difficult for organizations to synthesize this into concrete legislative regulations. It is commonly agreed that this model is a much better representation of disability, but its intangibility will thwart societal changes. An example of this is the World Health Organization’s continued support of a medical model style of disability definition. Their interpretation of disability centers on the functionality of disability,

rehabilitation, and health care efforts catering toward disability, with no mention of societal reform (see www.who.int). Only when we see definitions of disabilities that mention social suppression as a characteristic of disability will the social model be recognized institutionally, despite its inherent existence throughout society.

THIRD MODEL OF DISABILITY

Today's disability geography discourse is premised upon the medical and social models of disability (Cormode, 1997). Many authors have concluded that one on its own does not fully account for the lack of accessibility that is fundamental to disability; instead, it is a commingling of the two models that builds the framework of spatial disability patterns (Gleeson, 1999). In a sense, the individual must still have the ability to carry herself through the landscape, provided all societal barriers were eliminated. However, to my knowledge, scholars in this field have yet to suggest a geographical model of disability that clearly defines the spatiality of disability. Now, it could be quite possible that this has not been suggested because academics see the heterogeneity of disability as impossible to represent with one absolute model. However, scholars who were interested in disability, not geography, developed the medical and social models. These models are the premise of the categorization of disability oppression and normalization techniques. Instead, I believe geographers should develop a more thorough geographical model that involves both models, which is widely accepted as the most accurate representation of disability.

The multiplicity of the landscapes in which disabled persons operate means that an absolute model is impossible; but this does not preclude geographers from developing a relative spatial model, with the person most affected by disability, the individual, at its core. I propose a model that uses concentric rings of acceptance, which emanate from the individual. The area immediately around the individual's primary environment—the bedroom, the home—is nearly always fully socially accepting of that person's disability (an admittedly general assumption); people with disabilities typically have the necessary social accommodations to that environment. As that individual moves farther away

from the base environment, her disability becomes more of a social problem, creating a gradient from fully medical to fully social. At some point far away from that base environment, the individual's disability is seen entirely as a social problem, where all the adaptations in the world would prevent the disabled body from being seen as normal. In this zone, the individual is seen as an outcast, her body viewed as a defective mechanism in the absence of a personified relationship with the glaring strangers.

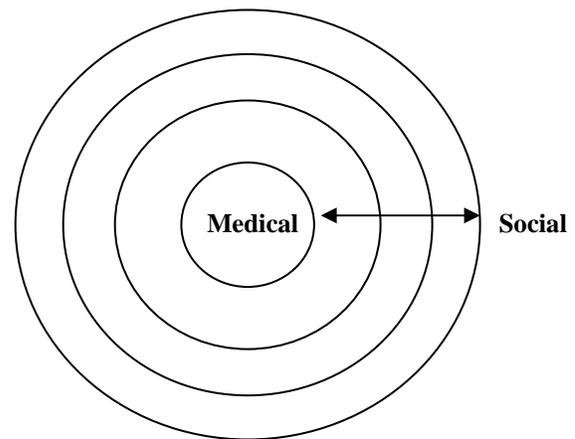


Figure 1: Third model of disability. Also in the center of this model is the individual.

This model is strictly elementary. I have no intent on backing this model up as a definitive model for understanding the problems of possessing a disability. What I hope to attain from this model is a basic spatial relationship of what I feel exists between the medical and social models. All of the zones are relative, and their exact magnitude is impossible to determine. The purpose of this is to show that the social limitations are eliminated within a certain base environment in which that person feels most comfortable. Conversely, another end of the spectrum exists in which the disabled person is seen as “wrong,” “substandard,” and deviant from the norm.

HISTORY OF THE DISABLED IN RUSSIA AND THE USSR

For centuries, the mentally and developmentally disabled in Russia and the mental

institution have gone hand-in-hand, thus creating pervasive social limitations to people with mental disabilities. The first major recorded care for disabled people was provided by the Russian Orthodox Church in the seventeenth century. The majority of the care in these years was within the family, this era actually being the time in which the greatest amount of mainstreaming and normalization to date occurred. But for the families who either lacked the ability or resources, whose relatives had ailments that required attention beyond what the family could give, and perhaps even families who simply did not feel up to caring for their disabled relatives, the Russian Orthodox Church took disabled people into their monasteries (Malofeev, 1998; Korkunov et al., 1998).

The first governmental intervention into disabilities came in the early 18th century under Tsar Peter I, the Great. Military service under his reign was obligatory for males, but exemptions were requested from families whose relatives were “*duraki* [fools] since birth” (Brown, 1989, 17). As tsar, Peter was reluctant to accept exemptions and concerned that such a practice would become widely known, and lead to massive prevarication in requests for pardons. To avoid such problems, in 1712, a method was created to verify the validity of disabilities; purported *duraki* were to be presented to the Senate in the new capital city, St. Petersburg, where the Senate would approve or deny an exemption certificate for *duraki* or anyone else who had disabilities such that they would not have the abilities to be of assistance in the military. Many disabled peasants consequently never attained exemption from the service because they lacked the means necessary to travel to the new, remote capital city. This marked the first Russian administrative interest into the actions of its disabled citizens, and in many respects, it began under accommodating and honorable reasons; but this seems to be the first step in a long line of disparaging controls over the lives of disabled people in Russia (Brown, 1989; Korkunov et al., 1998).

In 1723, Peter sought greater control over the mentally disabled population, switched care of the insane to the state, and ordered people to be prevented from being sent to monasteries. Peter was then succeeded in 1725 by a short series of tsars and czarinas who never spent long enough in power to delve far enough into domestic issues to concern themselves with such a minor issue as mental health

and disabilities within the population. Historical records do not indicate whether monasteries regained any power, Peter’s rules over monasteries were disregarded, or if this rule’s enforcement did continue (Brown, 1989; Korkunov et al., 1998).

Catherine II, the Great, was the first long term leader following Peter I, and she not only picked up where Peter left off, but she expanded upon his interest in the mental health population. Soon after her coronation, she officially transferred responsibility for the insane to the state, and elaborated upon this by establishing regional departments of public welfare throughout Russia. These new agencies were responsible for the establishment of madhouses to house the insane in their regions, and in a sign of the attitudes that surrounded these buildings, they became more commonly known as “Yellow Houses,” after the cheap yellow paint by which they were marked. These houses were used for a century, and in this time, they became progressively more accepted as the home for mentally disabled people rather than the chronically insane (Malofeev, 1998; Korkunov et al., 1998).

In the early nineteenth century, a revolution transcended Russia in the form of a more medical/psychiatric approach to the mentally disabled. Around 1840, the Yellow Houses were replaced by newly constructed or renovated asylums throughout the provinces of Russia. Whether due to the modernity of the updated facilities or social demand, the new asylums quickly filled to capacity and became a financial bone of contention between the national and provincial governments. Neither side was willing to increase funding to the facilities, so an official decree was published that sent all but the most dire patients back to their families—at least the second such eviction from these and similar facilities (Brown, 1989).

Official government records regarding the release of the less dependent patients have been found, but no statistics are available as to the amount of patients who were returned to their natural families. What is certain is immediately prior to the Bolshevik Revolution, funding had eroded to catastrophic levels, and a similar diktat ordering the eviction of the remaining patients was released. The majority of these people were, in reality, sent into foster homes, and when extra support was necessary, entire communities were given caring responsibilities

for the released patients (Brown, 1989; Malofeev, 1989).

The unfortunate fate of the final wave of released patients was effected by the comprehensive changes in government and the effects of war and revolution that destroyed the nearly retired asylums circa 1917 during the Revolution. Suffice it to say, the disabled citizens of this period—former patients and not—filtered through an “abled” system that impeded all movement of the disabled, and led to the ultimate neglecting of their bodies. The succession of governmental attitudes only perpetuated their downfall, as the incoming communist ideologies sought a fully abled society that sought an entirely functional populace, which was capable of all industrial activities (Korkunov et al., 1998).

Under Communism, all people with disabilities, handicaps, “defects”, and the like were efficiently removed from the general population. Additionally, all healthcare was free, and hence, to care for relatives, it was necessary to follow the bureaucratic protocol to attain even the simplest services (Brown, 1989). Following the rise of communism in 1917, all subsequent disabled children were sent into “boarding schools,” located in major cities and inaccessible to their families—both geographically and legally. The “boarding schools” were the only form of healthcare available to disabled children, leaving little alternative for their families. These were further mandated through a rule that outlined the regulation and complete removal of disabled people from their families and society in general (Malofeev, 1989).

The special education policy did not provide a way to help the family keep the child, or even to keep in contact with the child. In this special education system, the child’s all-around developmental needs were not considered; instead, the primary goal was to use administrative means to perfect the organizational function of the state.

Korkunov et al., 1998, 187

Russian scholars now recognize the blatant hypocrisy of this system, despite the few financial and therapeutic advantages of the “boarding schools” (Pervova, 1998). Certainly, this was a top-down imposition on disabled people and their relatives, and it never was really accepted as a positive solution to anything aside from minimal shelter, food, and clothing for disabled children as they grew into adults

(Pervova, 1998). What is further interesting is the reference between the “boarding schools” and special education, which are related in the discourse of multiple Russian academics, not just Korkunov (see Iarskia-Smirnova, 1999; Pervova, 1998). The mere association of special education and the boarding schools, though possibly a problem in translation, indicates even an existing cleavage between western and Russian thought regarding this style of education. Time and again, the boarding schools are discussed in the same context as special education, while these institutions were neither schools nor places where remedial skills of any capacity were imparted. These places were the only homes any of their inhabitants knew, and were their ultimate destination. They simply rotted away inside these asylums; education was nonexistent.

A similar disparity differentiates parlance within the special education field itself. In the United States, for instance, the terms that refer to people with disabilities take every stride to remain neutral and neither escalate nor offend its constituents, as evidenced in the term “special education,” the rejection of “retarded,” and the new emphasis on “people” with whatever disability that they possess. Many critics argue that these emphases are simply a by-product of the political correctness campaign of western liberalism and these terms are only what we make them. Such arguments are warranted, but only because all terms that have been used in our recent past are not severely offensive. In contrast, Russian special education exemplifies the need for some label barriers and the associated “othering” of certain peoples, as their term for special education is *defectologiya*, or translated, “defectology”—the study of defective people. All communist records refer to disability and disabled people as defective—dissidents from the industrial norm and rejecters of the normal body (Pervova, 1998). Such institutional biases are crucial to this paper, as these are the foundation of stereotypes that are crafted from childhood.

CONTEMPORARY RUSSIA

Without say, extensive modifications were made in all Soviet policies in the change from communism to democracy, including treatment and attitudes toward the disabled. Much of the new principles are outlined in *The Constitution of the Russian Federation of 1993*, which outlined the liberalization of the federal agencies and the removal of social barriers to disabilities. In content, this series of documents is a necessary and proper force in the overhaul of the prejudiced practices of its predecessors' policies. It calls for the democratization of healthcare policies and individual geographic, political, and social freedoms. It describes a new humanitarian approach to mental disabilities, and describes a country that accepts handicaps, provides universal [special] education, and freedom and mobility for all. With such a powerful rebuttal to previous attitudes, and given that a decade has passed since the legalization of this proposition, one begs to ask: has this worked? Have attitudes, prejudices, and hypocrisies changed? To what degree does today's disabled citizen have freedom and mobility? (Grigorenko, 1998; Kikkas, 2001; Pervova, 1998)

In the original Stalin Constitution of the USSR, work was embodied as "the duty and honor of every able-bodied citizen" (Brown, 1989). In the liberalization of the Russian society in the 1990s, the Soviet lifestyle proved insurmountable to many facets of the democratizing process. The sweeping legal changes that evolved from the new constitution were never fully implemented—especially in disability services and acceptance—as part in parcel to the mentalities of the body politic. With exception of several enclaves of universal acceptance and highly liberalized areas, the majority of Russia still operates within the disabled framework of the USSR (Kikkas, 2001).

The 1993 Constitution called for a special education system similar to that of many western educational frameworks, and the collapse of the fallacious "boarding school" premise. Special education, which was still labeled defectology but nevertheless advancing in a positive direction, was mandated in all school districts, as classrooms among the abled rooms. Subsequent to this declaration was the introduction of defectology into the teaching curriculum at institutes of higher learning. This

curriculum has indicated few deviations from the Soviet principles, and is still largely premised upon the biological theories of research that led these new graduates to emphasize the medical holdbacks of disability rather than the social. The emphasis on past ideologies is ameliorated by the mostly uneducated defectologists, also known as special education teachers; in 1998, only about 9% of special education teachers possessed specialized training in post-Soviet defectology (Kikkas, 2001; Korkunov et al., 1998).

School placements have also resisted political metamorphosis, and many children are still being placed into boarding schools as soon as developmental disabilities are observed. Many of the regulations surrounding these institutions have changed, but they still practice the migration of children who are deemed "dumb," "stupid," "defective," and "delayed" to industrial centers (Korkunov et al., 1998; Pervova, 1998).

The reformation rules require parental consent for all placement and educational decisions, but sufficient input is still absent. Parents are ill- and misinformed about the resources to which they have access, and they are confused by a newfangled bureaucracy to whose rules they are not accustomed. The fault of this misinformation is obscure; the new agencies are hierarchal to the extent that the medical and educational professionals are mere messengers of the bad news. Still, the organization of these institutions remains influenced by the past century, and it seems that once children enter, they never travel more than a few miles away from the boarding school (Pervova, 1998). Practically, social barriers erected by the system of institutionalization, which are supported by continuing ideologies that portray disabilities as socially insurmountable, are pressuring these kids from ever infiltrating the disability-resistant areas of Russian society. It is practically impossible for a disabled Russian child to receive a status quo education.

One positive change that democracy has brought is the existence of the aforementioned enclaves of acceptance. St. Petersburg seems to be the foremost example of a center of acceptance, a place where many social support programs assist people with disabilities in attaining normal lifestyles. Not only does this area house the most liberal schools of "special education" (feats within themselves, most schools are still named defectological institutes), but they are supported by many governmental, social,

economical, medical, and professional institutions that all seem to strive towards a fully inclusive society. These few areas are certainly the exception and not the rule, but they positively reflect a change from Soviet tradition and the coming downfall of the intense othering of disabled people (Iarskia-Smirnova, 1999).

One final general issue that is plaguing the disabled plight in Russia is the autonomy of assessments on disabled citizens. The new hierarchy of the body politic has eliminated collaboration among specialists in various curriculums. The subordination of some and the superior ranking of others prevent comprehensive evaluations of the individual. The prevalence of ex-Soviet medical professionals in high-ranking positions within the various agencies obscures the suggestions and progress of new styles of treatment, education, and employment of disabled people. Educationally, parents are led to believe isolation is the only “cure” for their unique children; economically, disabled people are erroneously told that they lack the abilities to support themselves; and socially, families whose members are disabled are accused of supporting a deviant. Indeed, changing attitudes has proven to be much more difficult than governmental policies, and disabled people are captive victims of these guidelines (Korkunov et al., 1998).

THE RUSSIAN SERVICE-DEPENDENT GHETTO

In a commonly reminiscent image of the fall of communism, the emergence from the command economy and the containment of the institutions has been symbolized by the razing of their perimeter walls. But contradictory to the Berlin Wall, the disabled people had nowhere to go against the friction of the public surveillance directed toward them. The workforce never regained acceptance of disabilities, and few disabled people have ever escaped or been rescued from their carceral residences. The remaining stereotypes have left the disabled people in their ghettos in former industrial centers, living fossils of times long past. For much of Russia, the fall of communism was also the fall of large-scale industry and the emergence of a diasporization similar to the sub- and ex-urbanization of many other postmodern advanced states. The few

people left behind this wave are the underprivileged, unskilled, unaccepted poor who lack the necessary means to partake in this migration. Relatively, the scale of de-urbanization has not been as large as most western states, but the de-industrialization has been as large if not larger than others. The immobility of disabled people has created virtual red zones where unofficial rules warn abled people from visiting (Malofeev, 1998). To follow the sprawl, one must have the ability to disregard the larger social functions affecting their disability—an unaccepting workforce, an abled landscape, no professional services for people with disabilities, and few social connections with other similarly disabled people. It is in this capacity that disability becomes socially constrained.

The aforementioned processes are part of the larger repudiating forces that work to further isolate the “mental health ghettos” beyond the small physical barriers. Conversely, many cohesive forces are dually hindering the escape from these areas. First, the services that support these people, if few and far between before, are less available in the new economy. No disability support services have established themselves on the exterior of the inner-cities because no people in need of these services live in other regions; the services that are available in any capacity are located in the new ghettos. To leave the neighborhood and live a life among abled people requires losing the services, support, and accessibility that exists within disabled areas. What comes to mind is recent research on the development of gay enclaves that allow previously unheard of levels of comfort. So called “gayborhoods” allow gay citizens to live amongst people of the same ideals, thus creating an environment free of the persecution of larger society. These areas, for both disabled people and gay people, are a respite from the surveillance of the larger carceral city. Indeed, significant differences separate these two groups, and I do not want to suggest homosexuality is a disability. A primary difference, and reason for less enticement of this idea for disabled people, is that gayborhoods often are a sanctuary only during off-business hours; that is, gay people have the freedom of traveling anywhere in the city and then return to their neighborhood. Disabled people in these situations lack that ability, and are never seen in other areas—a definite setback in the quest for social normalization (Iarskia-Smirnova, 1999). To venture away from these areas entails

venturing into a landscape that lacks accommodations to disabilities.

This general trend of these disability ghettos is not to say that the populations are entirely trapped in these places. Not only have some moved out, but others live within and have normal social networks outside their locality. The landscape is still resistant to those who have ventured out, but some have regained or created anew family and local contacts from their place of birth. The majority of this group has been rescued from their lives in the institution, leaving their family (or whomever) the full responsibility of constructing an accessible landscape (Grigorenko, 1998). In these situations, the model simply relocates. The new socially accepting nucleus is the new home with socially resistant forces throughout the new circumferential landscape.

FRAMING THE FUTURE

The characterization of the service-dependent ghetto has thus far been painted as a product of the mental institution's instantaneous infrastructure breakdown. Sans the support network that was available within the government's healthcare system, these populations became a static body within the neglected areas of the otherwise modernizing city. And to an extent, this is true; but as previously mentioned, this same pattern has formed in western culture. The distinction between these cultures is important in realizing the uniqueness and simultaneous commonality that Russia's disabled populations face. The hurdles that will be necessary to overcome in Russia are different than the hurdles to overcome in the normalization of disabled people here, but the processes of change will share many mutual threads. Though the model has been applied in this unique environment, its effectiveness holds true in western cultures, as well.

Table 1. Dynamics of Change in Special Institutions

Year	Number of Special Schools	Number of Pupils in Special Schools and Special Classes
1970	1,271	204,800
1975	1,450	245,800
1980	1,516	262,500
1985	1,614	294,800
1990	1,791	315,300
1992	1,821	394,800

Data from Korkunov et al. 1998

Plans to integrate disabled people into the rest of society are nothing new, and many exist, especially here in the United States. Indeed, so many of such plans exist that I am currently incapable of even beginning to accurately summarize these plans in this paper. Consequently, I am a student here of general patterns that have emerged in this discussion. Most of the plans of this capacity involve the recognition that the services that cater to these populations are the primary continuing binding force of the service-dependent ghetto, a theory to which I subscribe. What is subsequently addressed, usually, is the encouragement of the reestablishment of these services in different regions, with the goal that this migration will promote an equally risky move of the disabled population. This is a commonly debated topic in western literature, with seemingly everyone agreeing with this but no one agreeing how to do this. Many scholars suggest that this would only replace these ghettos with dispersed micro-ghettos. What we should instead strive for is a society with universal mobility (Dorn, 1994).

The essence of contemporary Russian disability has been portrayed thus far as a socially-resisted embodiment. To "solve" the problem of disability, the social barriers will need to be razed. In Russia, it is still possible to reform the structure of care that disabled people receive so that it is all-encompassing throughout the landscape. The services that disabled people require—remedial, medical, and accommodative services—can still be modified into a form that is completely revolutionary. Beyond a public healthcare system, and certainly beyond the

socialist system, an exemplary approach must be available that will make the support that disabled people need possible, releasing them from the trappings of dependence on specific supports. The supports for disability do not have to be bound; they can be universal. For instance, a few specialized doctors can be replaced with collective disability-educated doctors; special education classrooms can become parts of every school; and familial supports like social workers can sprawl into occupation of wider areas.

Pondering the future also must include—guess what—the future. All of the aforementioned circumstances apply to the population that was contained in the inner-cities as a result of Soviet-era policies. As times progress, it is expected that people with disabilities will remain contributive members of their families, instead of being sent away. Current statistics are troubling in this regard, still indicating dominance of special schools over small populations of special education students throughout all schools (Pervova, 1998). Special education should become an extensive system that allows disabled students to live near home. And as the students graduate from the school system, some will inevitably need to move to group facilities. Said facilities should replace institutions for individuals whose care are beyond domestic abilities, and should remain local, allowing continued involvement in place of previous desertion of these individuals. These facilities will require funding, which is unarguable. How this capital will be attained is debatable. Certainly, these facilities must not be neglected; in fact, western service-dependent ghettos formed after the poor transition from institutions to group homes. They were poorly funded and imploded as a result of poor funding (Dorn, 1994; Gleeson, 1999). Such mistakes should not be repeated in Russia. Proper funding, which should not be mischaracterized as exorbitant amounts of money, will allow these individuals to participate in their communities. Their continued involvement in their communities through employment, philanthropic work, and recreation will advance the persona that currently emphasizes their inabilities as opposed to their abilities. Ideally, these persons will not live far from home, which will allow unbroken involvement and relationships with their families.

Finally, I ask readers to not see the similarities of these ideas and the situation in the United States and infer that this plan aims to mimic

the American disabilities structure. The system that I propose may appear analogous to the American system, but it is not. I argue here that Russia should move towards a society that involves people with disabilities in all aspects, niches, and locales of life. Though some people with disabilities may require residence in serviced facilities, these facilities should actively include these people in all communal activities, should be located among other houses, and should be funded and governed by the public. Public funding should not be in the form of governmental sovereignty, rather in a more democratic form of housing. Is it not possible to manage these facilities through local democratic processes? Research shows the Russian society to be advancing towards more local democratic subdivisions (Reddaway and Orttung, 2004), and such partitions would augment the ability for group homes to become elements within their surrounding areas. I envision these homes operating in correspondence to the local governments, giving them the ability to annex the resources of the government without the troubles of bureaucracy. The core of this plan is involvement: involvement of disabled people in the community, and the involvement of the community in the advancement and normalization of disabled people. Involvement here will be the key to normalization of disabilities and the eradication of preexisting social barriers of mobility. This will not do it alone, but it will eventually be the force that razes the foundation of stereotypes upon which current segregation is built. Such a transition would erode both the medical and social barriers of Russian disability. Although the United States may demonstrate different calibrations of these forces, it would be erroneous to believe this model, and the power of social barriers, can only be applied to Russia. Many barriers to disability in the United States are social in nature, and the barrier-free concept that has been outlined could also work in the United States, if applied. Though these societies are vastly different, the current disabled populations' mobility are largely similar. The take home message is, if anything else, that the removal of social and medical barriers can follow the same path in both countries, despite widely varying historical processes that shaped the contemporary disability cultures in each county.

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