

IL NET

an ILRU/NCIL National Training and Technical Assistance Project

Expanding the Power of the Independent Living Movement

WORK SMARTER, NOT HARDER: “OUTREACH MADE SIMPLE”

A National Conference

Participant's Manual

August 11-13, 2003

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New Orleans, LA

August 11-13, 2003

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Work Smarter, Not Harder: “Outreach Made Simple”

Agenda

Monday, August 11

- | | |
|---------------|--|
| 8:30 | Continental Breakfast |
| 9:00 – 9:20 | Introduction, Housekeeping, Learning Objectives, and Norms |
| 9:20 – 9:50 | Why do we need this? Why is this training important? What are some benefits of effective outreach? |
| | Four Key Elements to Effective Outreach |
| 9:50 – 11:00 | 1. Who are we serving? Identifying populations |
| 11:00 – 11:15 | Break |
| 11:15 | 2. What do we Know? Understanding Cultures |
| 12:30 – 2:00 | Lunch |
| 2:00 – 3:15 | 3. How does your center look externally?
➤ PR, Marketing and Networking |
| 3:15 – 3:30 | Break |
| 3:30 – 4:45 | 4. How does your center look internally?
➤ Staff and Board Planning |
| 4:45 – 5:00 | Pluses/Wishes |

Tuesday, August 12

8:30	Continental Breakfast
9:00 – 9:15	Check-in and Review
9:15 – 10:30	Present four scenarios for outreach from fictional centers
10:30 – 10:45	Break
10:45 – 12:00	Reporting and Discussion on scenarios
12:00 – 1:30	Lunch
1:30 – 1:45	Implementation and Evaluation
1:45 – 3:15	Home Center Analysis and Assessment using demographic info ➤ Key Questions from scenarios
3:15 – 3:30	Break
3:30 – 4:45	Analysis Presentation and Critique
4:45 – 5:00	Pluses/Wishes

Wednesday, August 13

8:30	Continental Breakfast
9:00 – 9:15	Check-in and Review
9:15 – 10:15	Visioning Exercise
10:15 – 10:30	Break
10:30 – 12:00	Construct Individual Outreach Plans based on the assessment, scenario questions, and visioning exercise ➤ Planning Worksheets
12:00 – 1:30	Lunch
1:30 – 2:45	Sharing of individual plans with large group
2:45 – 3:00	Evaluations

About the Trainers

Susan Madison works for the National Association of Developmental Disabilities Councils based in Washington, DC. Formerly, she served at the National Council on Disability as their Public Policy Fellow, as the Executive Director of Arizona's Governor's Council on Developmental Disabilities and for a Center for Independent Living. Her 20 years of experience in the disability field include training for California's Crime Victims with Disabilities Initiative, serving on numerous Commissions and Boards, and Chairing Arizona's Statewide Independent Living Council.

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Liz Sherwin has been employed by the Illinois-Iowa Center for Independent Living (IICIL) since 1988 and is the Executive Director. Ms. Sherwin is currently president-elect for the Coalition of Citizens with Disabilities in Illinois and a board member of Association of Programs for Rural Independent Living (APRIL). Ms. Sherwin developed a plan to improve services for "unserved and under-served" that addressed urban and rural communities with significant African-American and Hispanic population. The IICIL was awarded an ILRU recognition for Outstanding Rural Outreach Services in 1992. ILRU, again in 2000, recognized the Center for outreach services to people who are deaf and hard of hearing. She served as a member of the Illinois Statewide Independent Living Council (SILC) Outreach committee and helped draft their plan for serving un-served and under-served populations. Liz conducts community training on the ADA and other legislation that protect the rights of people with disabilities and has been a national presenter on outreach to un-served and under-served populations.

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ABOUT ILRU

The Independent Living Research Utilization (ILRU) Program was established in 1977 to serve as a national center for information, training, research, and technical assistance for independent living. In the mid-1980's, it began conducting management training programs for executive directors and middle managers of independent living centers in the U.S.

ILRU has developed an extensive set of resource materials on various aspects of independent living, including a comprehensive directory of programs providing independent living services in the U.S. and Canada.

ILRU is a program of TIRR, a nationally recognized, free-standing rehabilitation facility for persons with physical disabilities. TIRR is part of TIRR Systems, a not-for-profit corporation dedicated to providing a continuum of services to individuals with disabilities. Since 1959, TIRR has provided patient care, education, and research to promote the integration of people with physical and cognitive disabilities into all aspects of community living.

ABOUT NCIL

Founded in 1982, the National Council on Independent Living is a membership organization representing independent living centers and individuals with disabilities. NCIL has been instrumental in efforts to standardize requirements for consumer control in management and delivery of services provided through federally funded independent living centers.

Until 1992, NCIL's efforts to foster consumer control and direction in independent living services through changes in federal legislation and regulations were coordinated through an extensive network and involvement of volunteers from independent living centers and other organizations around the country. Since 1992, NCIL has had a national office in Arlington, Virginia, just minutes by subway or car from the major centers of government in Washington, D.C. While NCIL continues to rely on the commitment and dedication of volunteers from around the country, the establishment of a national office with staff and other resources has strengthened its capacity to serve as the voice for independent living in matters of critical importance in eliminating discrimination and unequal treatment based on disability.

Today, NCIL is a strong voice for independent living in our nation's capital. With your participation, NCIL can deliver the message of independent living to even more people who are charged with the important responsibility of making laws and creating programs designed to assure equal rights for all.

ABOUT THE IL NET

This training program is sponsored by the IL NET, a collaborative project of the Independent Living Research Utilization (ILRU) of Houston and the National Council on Independent Living (NCIL).

The IL NET is a national training and technical assistance project working to strengthen the independent living movement by supporting Centers for Independent Living (CILs) and Statewide Independent Living Councils (SILCs).

IL NET activities include workshops, national teleconferences, technical assistance, on-line information, training materials, fact sheets, and other resource materials on operating, managing, and evaluating centers and SILCs.

The mission of the IL NET is to assist in building strong and effective CILs and SILCs which are led and staffed by people who practice the independent living philosophy.

The IL NET operates with these objectives:

- Assist CILs and SILCs in managing effective organizations by providing a continuum of information, training, and technical assistance.
- Assist CILs and SILCs to become strong community advocates/change agents by providing a continuum of information, training, and technical assistance.
- Assist CILs and SILCs to develop strong, consumer-responsive services by providing a continuum of information, training, and technical assistance.

Work Smarter, Not Harder: “Outreach Made Simple”

Purpose of Outreach Training

- Successful outreach approaches
- Develop strategies
- Implement plan
- Evaluate effectiveness

Learning Objectives:

Participants will be able to:

- 1) Identify effective methods for outreach to un-represented and underrepresented populations;
- 2) Describe and respond to cultural differences which influence how people with disabilities participate in and benefit from independent living services;
- 3) Create ways to network with agencies, governmental units, consumers, funders, and other interested parties;
- 4) Structure and manage programs more effectively to respond to service, funding, distance, and attitudinal barriers;
- 5) Develop a long-range plan to meet current and future needs.

Four Key Elements to Effective Outreach

For effective planning for independent living, it is necessary to build a comprehensive package, which addresses each of the four elements.

Can You Answer the following:

- **Who will we be serving?** -Identifying populations
- **What do we know?** – Understanding cultures
- **How does your center look externally?** – Public Relations, marketing, and networking
- **How does your center look internally?** – Staff and board planning

WHO ARE WE SERVING?

IDENTIFYING POPULATIONS

UNREPRESENTED AND UNDERREPRESENTED

Know the demographics in your service area. Outreach planning activities will depend on the racial, ethnic, disability, age, gender, socioeconomic status, and geographic profile of your service area.

Demographic And Geographic Profile of The Population According To:

- * Age
- * Gender
- * Racial and Ethnic background
- * Disability: physical, hearing, visual, cognitive, psychiatric, developmental disabilities, and others.
- * Residential status: large/small institutions, nursing homes, hospice, with family or friends, independently
- * Socioeconomic status
- * Rural vs. Urban
- * Other groups with a higher than average representation in a service area, (e.g., Rehabilitation facilities, workshops, etc)
- * Religion/Faith Community

Community Resources and Needs Assessment

- * Affordable and Accessible Housing
- * Affordable and Accessible Transportation
- * Mainstreamed Employment Opportunities
- * Mainstreamed Educational Opportunities
- * Natural Community Supports (for example):
- * Personal Assistant Services, ASL Interpreters, TTY Access in public agencies and businesses, Alternate format (Braille, tape, disk, etc.) in public agencies and businesses
- * Respite Care
- * Accessible Retail Stores
- * Accessible Recreation
- * Peer Mentoring Programs
- * Youth Leadership Conferences/activities
- * Accessible public services and facilities

What organizations, programs, and services are already available?

Do these organizations and services promote the independent living philosophy?
Are people satisfied? Why/why not?

What are the key issues that persons with disabilities would like to address?
How do you know what they are? (surveys, other agency's data)

Based on the demographic profile, who is not being served and why?

- 1) What are the barriers (environmental, geographic, attitudinal, skills, resistance to IL philosophy and knowledge) that must be addressed?
- 2) What local organizations might support CIL activities?
- 3) Examples of any effective outreach successes

Potential Sources for Finding Information (may include):

- *CIL 704 Report-demographic page
- *Bureau of the Census - www.census.gov
- *Bureau of Vital Statistics
- *Chamber of Commerce
- *City and County Planning Departments
- *Community Action Centers
- *Local College and University libraries
- *United Way
- *Public Housing Authorities
- *Urban Leagues
- *NAACP
- *State agencies serving people with disabilities
- *AARP

How to Get Information:

- a) Local sources:
 - Utilize telephone and service directories
 - Libraries
 - Community Colleges and Universities
 - City and County Planning Departments
 - Local ethnic and service organizations
- b) State sources:
 - Department of Human Services
 - Rehabilitation Services
 - Statewide Independent Living Councils
 - Assistive Technology Projects
 - Disability and advocacy councils and organizations
- c) National sources:
 - Independent Living Research Units

National Council on Independent Living
National Council on Disability - www.ncd.gov
Census Bureau-www.census.gov
National Organization on Disability – www.nod.org
American Association for People with Disabilities-www.aapd-dc.org

Please keep this in mind:

Definitions of disability must be clear and specific. Don't assume that your definition of "disability," "deaf," or "blind" is identical to the definition used in a study.

For example, if a local United Way study finds that 14 percent of the community's population is Latino, and a local Chamber of Commerce study finds that 18 percent of Latinos are unemployed, don't apply the unemployment percentages to the population percentages (this is like mixing apples and oranges). Unless the data are from exactly the same sample, you can't assume there is any connection between the two.

Citing the population and unemployment percentages from both sources can support a service need and is perfectly reasonable as long as you do not assume a connection between the two. Gathering statistical information is only the first step to outreach.

WHAT DO WE KNOW?

UNDERSTANDING CULTURES

Know and Respect Cultural Differences

Taking time to know and respect cultural differences gives life to the information gathered during your research. Not all cultures understand or accept the Independent Living philosophy, as it is perceived by Centers for Independent Living. Therefore, one cannot assume the target group needs, wants, or can access the CIL's current services. The most important goal is to collect information from un-represented and underrepresented groups in a way that is open to understanding and respecting their cultural context.

We must find solution to these questions:

How do we demonstrate community support for those needs?
How can CILs adjust their programs to meet those needs?

**These questions are important because they demonstrate that the CIL is not just selling its own activities and services, but has a genuine interest in the needs of that community or cultural group.*

Ideas to incorporate in the planning process for effective outreach:

*Respect and include the cultural language, traditions, beliefs and spiritual perspective of the target population.

*Understand that the social and economic climate of the population is important, because disability may not be a primary concern

*You cannot stereotype cultures.

*You must have knowledge of the community and their issues and priorities.

*It is important to know the leaders and key players

Important Questions to Consider

- What are the community needs
- How can CIL demonstrate support
- How can CIL programs be adjusted to meet the needs

Know Your Communities:

- a) Identify individuals in your neighborhoods or communities who are bilingual and bicultural to work with your CIL and help you through this process.
- b) Use a reliable method to gather information to access that population, such as:
 - ...Conduct focus groups
 - ...Conduct interviews
 - ...Conduct mail or telephone surveys
 - ...Assess CIL information and referral data (704 Report)
- c) Develop a list of issues or information you need to know in order to serve your target population.
- d) Conduct relevant outreach training for staff and board-utilizing representatives of the un-represented targeted group.

Build Partnerships

- a) Invest in the community by having CIL representatives participate in activities that are relevant to the targeted population, not just those that concern Independent Living.
- b) Work with effective community based organizations that provide services to targeted populations to:
 - >Understand their programs and services
 - >Find ways to have CIL services compliment theirs
- c) There should be representation on the CIL board and staff of qualified individuals from un-represented and underrepresented populations and communities.
- d) Recommend potential leaders with disability to serve on other organization's boards and committees.

HOW DOES YOUR CIL LOOK EXTERNALLY?

MARKETING, PUBLIC RELATIONS, AND NETWORKING

Utilize the needs and issues identified about the targeted population and incorporate these into the Center for Independent Living's (CILs) Strategic Plan.

Develop a public relations campaign using the information and ideas gathered from your analysis or needs assessment. Monitor the effectiveness of the campaign.

Create outreach materials, which target the needs of specific populations in your service area.

CIL materials should be accessible to all potential consumers. Printed information (letters, brochures, applications, etc.) should be:

- >Written at a reading level that is easy to understand.
- >Avoid acronyms and professional phrases that are not easily understood by the intended audience (i.e., what does ILS or 'independent living skills' mean?)
- >Written in a language that can be understood (i.e., everyday Spanish, not necessarily the courses they taught in school).
- >Accessible in a variety of formats such as Braille, large print, tape and disk.
- >Qualified persons should edit and proof materials in other languages.

Monitor the effectiveness of your public relations campaign by reviewing your service demographics and by talking to representatives of your target population.

1. Get feedback from representatives of your target population.
2. When information is provided in another language, ensure staff is readily available to communicate effectively.
3. There should also be a process in place to address other cultural issues, such as language or religion.

Getting information to the General Public

- Information should be accurate and cost-effective. The media package should clearly understand and articulate the mission, services, and activities of your CIL.
- Train Board and staff on how to interact with media
- Designate a lead person to provide public information
- Maintain current list of media contacts (newspaper, radio, television)

- Develop personal relationships with local media people (reporters and others who have access to the media)
- Be ready to respond to issues that affect people with disabilities in editorials and opinion pages, list serves, advocacy or public policy information and email alerts.
- Build a public and community history by keeping press releases, newspaper articles, televisions, and radio spots.

Enhancing Your Public Relation Strategies:

*Utilize existing mailings (i.e. banks, utility companies, Chamber of Commerce and other organizations).

*Develop partnerships in your advertising, (e.g., get a local college or university to donate time, materials and students to develop a local commercial or Public Service Announcement (PSA)

*Respond to issues, which are hot or controversial in the local media. Include issues that affect un-represented and underrepresented populations, not just independent living issues. This will allow you a greater opportunity to gain your community's trust.

1. Create opportunities through radio, TV, and newspapers on a regular basis
Regular disability information segments (on a local television magazine show or local radio program), a regular disability program on public television, or a regular column in a local newspaper or newsletter.
2. Use your own monthly calendars and newsletters to share information.
3. Provide Website updates or email alerts

Get the word out at little or no cost to you:

- Network with specific disability agencies for a group campaign
- Expand partnerships by getting individuals with disabilities on Boards and Commissions such as the Urban League, YMCA, and school boards.
- Set up videoconferences with other organizations to assist consumers with transportation costs.
- Share information on your website, use list serves and group emails for quick and efficient alerts to consumer groups, social service organizations and health agencies.

- Take advantage of state and federal laws requiring media organizations to give free time and PSAs to local not for profit organizations. Be sure to talk about (and perhaps negotiate) when the PSA will be aired.
- Establish a link with an organization to produce a disability issues program on public television or radio.
- Contact an advertising club, particularly if there is a “junior” club that can donate hours to local non-profits
- Locate good, generic videos or audio programs (short commercials or a 30-minute cable program) explaining a Center for Independent Living for airing on television and radio.
- Get a grant to underwrite the cost of producing a video about your CIL that could get aired locally

HOW DOES YOUR CIL LOOK INTERNALLY?

BOARD AND STAFF PLANNING

Board and Staff Outreach Strategies

- “Operate in a manner that is sensitive to and respectful of ethnic and disability culture”
- ...Recruit qualified staff and board who represent the demographics of your community
 - ...Employ staff from the constituency you are trying to reach
 - ...Create and maintain linkages for present and future staff needs
 - ...Conduct activities that enhance cross-cultural sensitivity
 - ...Develop cross training with other organizations and agencies by:
 - Organizing a committee to develop CIL training needs and send invitations to populations to provide technical assistance or to conduct the trainings.
 - Requesting that staff, board, consumers and agency contacts assist in identifying facilitators and trainers.
 - ...Open satellite or branch offices or share office space with another agency 1 day a week or more
 - ...Work with disability agencies to develop a common advocacy agenda
 - ...Have toll free phones numbers for outlying areas

WHO ARE WE SERVING? **IDENTIFYING POPULATIONS**



Your Task:

Using some of the strategies identified, and the collective thoughts of your group, over the next 30 minutes answer the following questions:

1. Who - Who do we want to provide outreach to?
2. What - What do we know about the population?
3. Where-Where do we start implementing it?
4. When - When should this process be started and completed?
5. How- How will we evaluate or know if we have succeeded?

When Completed:

6. What outcomes will be measured?
 - a. What are cost benefits?
 - b. What is the satisfaction level of consumers?

Your Situation:

You have a three county service area with the CIL located in a city of 125,000 people. There is large Latino and African American communities located there as well Caucasians. Suburban communities surround the city and the remainder of the service area is predominantly rural.

In the city and suburbs, there are a number of services available such as community agencies, State VR offices, City Hall, NAACP Chapter, churches, faith groups, etc. Outside of the city, there are no transportation systems in place.

When the Center conducted an analysis of its direct services data for the last three years, it found that over 90% of their consumers and 100% of its staff were Caucasian, and primarily from the city where the Center is located. The organization, including the Board of Directors, wants to drastically change this trend.

WHAT DO WE NEED TO KNOW?
UNDERSTANDING CULTURAL NEEDS



Your Task:

Using some of the strategies identified, and the collective thoughts of your group, over the next 30 minutes answer the following questions:

1. Who - Who do we want to provide outreach to?
2. What - What do we know about the population?
3. Where-Where do we start implementing it?
4. When - When should this process be started and completed?
5. How- How will we evaluate or know if we have succeeded?

When Completed:

6. What outcomes will be measured?
 - a. What are cost benefits?
 - b. What is the satisfaction level of consumers?

Your Situation:

Lakeville County is projected to become increasingly multi-cultural over the next decade. In Lakeville, the county projections for all Latino groups (i.e., Puerto Ricans, Mexicans, Cubans, etc.) indicate a growth of 34% in the next decade.

The Lakeville County area continues to consist of largely segregated communities. Latinos often live in isolation from the community at large. Many minorities with disabilities who had contact with service agencies in Lakeville County reported problems of specifically:

- ...Negative racial attitudes;
- ...Cultural differences;
- ...Language difficulties; and
- ...Feelings of being misunderstood.

The Board of Directors of the Lakeville Disability Rights Center for Independent Living believes their staff is not prepared to deal with the language and/or cultural differences. The Board of Directors has appointed a committee to develop a plan for appropriate methods of providing services and advocacy to these varied cultures.

HOW DOES YOUR CENTER LOOK EXTERNALLY?
MARKETING AND PUBLIC RELATIONS AND NETWORKING



Your Task:

Using some of the strategies identified, and collective thoughts of your group, over the next 30 minutes answer the following questions:

1. Who - Who do we want to provide outreach to?
2. What - What do we know about the population?
3. Where-Where do we start implementing it?
4. When - When should this process be started and completed?
5. How- How will we evaluate or know if we have succeeded?

When Completed:

6. What outcomes will be measured?
 - a. What are cost benefits?
 - b. What is the satisfaction level of consumers?

Your Situation:

A consumer who is deaf has filed a grievance that your CIL video and trainings as well as other meetings are not available in ASL.

This information was presented at a disability awareness workshop. Although consumers that are deaf minority group only represents 2.9% of the community, how should they be accommodated?

The CIL must develop a plan of action and implement strategy to respond to this grievance and address how CIL meetings become available to this sector of the community.

HOW DOES YOUR CENTER LOOK INTERNALLY? **STAFF & BOARD PLANNING**



Your Task:

Using some of the strategies identified, and the collective thoughts of your group, over the next 30 minutes answer the following questions:

1. Who - Who do we want to provide outreach to?
2. What - What do we know about the population?
3. Where-Where do we start implementing it?
4. When - When should this process be started and completed?
5. How- How will we evaluate or know if we have succeeded?

When Completed:

6. What outcomes will be measured?
 - a. What are cost benefits?
 - b. What is the satisfaction level of consumers?

Your Situation:

Your CIL is five years old and in the midst of a strategic planning process. Through analysis of internal operations and governance, the group has documented that the CIL:

- Board does not represent the demographics of your community
- Has no disability or cultural diversity reflected by makeup of current staff
- Consumer participation reflects lack of representation by minorities, which are just 2% of consumers served

Your community is a rural and urban service area, with the largest population of 40,000 and second largest of 18,000 people.

There are:

- A number of multi-county initiatives for service delivery (i.e., healthcare, transportation, aging, etc.);
- Disability services are available, although in limited scope;
- Minority organizations exist, but are not represented in city or county governments.

You are the Ad-Hoc Committee assigned the responsibility for making recommendations for:

...Outreach and organizational development;

...To increase diversity at all levels of the organization, Implementation, and Evaluation

ACTION PLAN AND EVALUATION

After the staff or board of a Center for Independent Living (CIL) consider the four elements of developing effective outreach, it is important to take the information collected and incorporate the information into an action plan for implementation.

1. Implementing an Outreach Action Plan:

- a) Target a specific cultural group, neighborhood, or community.
- b) Assign an outreach team and team leader for specific group targeted.
- c) Collect and review information and materials about the target group.
- d) Develop a time line of outreach objectives and desired outcomes.
- e) Develop a budget (for bigger projects).
- f) Implement initial outreach efforts.

2. Evaluating Outreach Effectiveness:

No outreach effort can be considered successful without conducting an evaluation of the of the CILs efforts to reach an un-represented or under-represented group. Adaptations of Crimando and Riggan (1988) identify three types of evaluation that can be useful:

a) Formative Evaluation: Formative evaluation is a series of activities performed to improve outreach through the design and implementation process.

- i) Have an expert review and comment on the content validity of the outreach objectives and effort.
- ii) Make changes in the outreach approach based on various information and data collected.
- iii) Try a smaller scale outreach "tryout" and revise the effort according to feedback gathered from the target group.

b) Process Evaluation: Process evaluation answers the question

How successful was the design of the outreach effort?

- i) Takes place during and after the implementation of the outreach effort.

ii) An outreach evaluation (usually one page) is a useful method for gathering feedback from the participants in the outreach effort.

iii) Make changes to the outreach effort based on feedback from the completed evaluations and interviews.

c) Outcome Evaluation: Outcome evaluation answers the question:

Did the CILs outreach efforts have the intended effect on the group, neighborhood, or community? Outcome evaluations measure the impact that the outreach effort reached and the un-represented or underrepresented persons with disabilities who have benefited.

i) Review data collected from 704 Reports to verify increased outreach efforts to a previously un-represented or under-represented group (e.g., disability group, minority group, and geographic group).

ii) Calculate a cost benefit analysis, which may be useful in future grant proposals for outreach efforts.

iii) Evaluate the success based on the satisfaction level of the persons reached through the CIL's outreach effort.

Analysis Worksheet

Who - Who do we want to provide outreach to?

What – What do we know about the population?

Where-Where do we start implementing it?

When – When should this process be started and completed?

How- How will we evaluate or know if we have succeeded?

When Completed: What outcomes will be measured?

- What are cost benefits?
- What is the satisfaction level of consumers?

Visioning Exercise

What do you want your ideal Center to look like? Imagine it's the year 2010. During this training you have acknowledged where your Center is now. Now we want you to imagine where you would like your Center to be in the year 2010. This is a tool to assist you in visualizing the future-without barriers. Imagine you have no Center at all-no building, no staff, no Board, nothing. You get to build from scratch incorporating the information on outreach that has been presented. Ask yourself honestly:

- 1) What would you want your Center to look like in the future?
 - Where is it located?
 - Is there more than one office?
 - What does the building look like?
 - What colors are there? Is there art on the walls? How is the space designed?
 - What sounds do you hear?
- 2) How many staff work there?
 - What ethnicity and age are they?
 - What disabilities do they represent?
- 3) How many Board members does the Center have?
 - What age, gender, and ethnicity do they represent?
 - What community do they live in?
- 4) What languages are being spoken at the Center?
- 5) What services and advocacy are being provided?
- 6) Does your Center have volunteers?
 - How do consumers, volunteers, and staff get to your Center?
- 7) The consumers who come to your Center- do they represent diverse cultures?
 - Cross-Disabilities?
 - Diverse ages?
- 8) What are the sounds? The sights? How does it feel?

Take a few moments and visualize your ideal Center. Now, alone, or with others from your CIL, write your answers on the form provided. Take about 25 minutes to write down the details, capturing your ideas and thoughts and then you'll have the opportunity to share some of them with the group. Remember, the more detail the better. Be as precise as you can, as you'll use this information later in developing your plans.

PLANNING WORKSHEET

To do effective planning with regard to independent living issues, it is necessary to build a comprehensive package which addresses each of the four Key Elements: 1) Who are we Serving? – Identifying Populations 2) What do we Know? – Understanding Cultures, 3) How does your Center look Externally? – PR, Marketing and Networking, 4) How does your Center look Internally? – Staff and Board Planning.

First determine the Goal that you would like to achieve by reviewing each of the four Key Elements with your demographic and census data and then ask: Who will we provide outreach to? What is the outcome we will expect? Second, answer the question: What do we need to do to effectively provide outreach to them? This will determine your Objective and list of activities or tasks. Last, with each activity or task, determine your time line for completion and who will be responsible.

Goal: _____

Objective: _____

Activities/Tasks:

What will be done?	Who will do it?	By When?

Appendix A

A COMMITMENT TO INCLUSION: Outreach to Unserved/Underserved Populations

by Carol Bradley

The ILRCSF Vision

Our vision evolved from the need of people with disabilities to feel included. As a center for independent living, we were committed to the values of consumer-control, cross-disability and broad community representation. All of these concepts reinforce the importance of listening to all of our consumers. The center for independent living environment is designed to create a place where persons with disabilities feel valued, understood, and welcomed. The result, consumer empowerment and inclusiveness fuel the "fire in the belly" to advocate for system change. A key component of changing attitudes toward people with disabilities is successfully modeling inclusion.

The movement is based on the principle that persons with disabilities are part of our larger community and that the needs of this part of the community should be considered equally. If we are asking the community to include those of us with disabilities, we, as part of the movement, need to demonstrate inclusion--diversity both in disability and culture. In order to expect success in consumer integration in the larger community, we need to demonstrate in our centers the value and benefits of inclusiveness.

San Francisco is a city whose unique character, richness, and teeming energy evolved from difference. In order to implement the independent living philosophy in the city, ILRCSF must reach many diverse groups. Celebration of difference is a fundamental part of independent living philosophy and is a necessity in a city with a strong heritage of culture and distinction.

Evolving A Framework

Needs assessment created a foundation for working paradigms. In some cases, we had multiple requests from consumers in the community and developed a program or approach to respond. In several cases, we examined the demographic data on consumers served and found a great disparity between persons coming into the center and the population in our community-at-large. This helped us determine under-represented populations.

Our experience taught us that just looking at pure demographics (generally referred to as underserved), is not indicative of whether or not services are needed. Numbers alone don't give a full enough picture. Instead, it triggers our need to do community organizing to determine what the needs are. In other words, we needed to position ourselves in a meaningful way to listen and hear community needs. Not all groups need independent living services. Some need a system of coordination; others need

credibility and support. Certain groups may need access to bilingual, bicultural staff. We all have limited resources, but every group deserves access to independent living services and exposure to consumer empowerment.

We began working with different disability groups and over time expanded into distinctive cultural groups. We developed key partnerships with community leaders who helped us respond to the unique issues in that community. We translated the independent living philosophy in a culturally/disability appropriate way and adapted services in a community-responsive way. By using and developing relationships in the community, we were able to expand our horizons. Those relationships helped lead to other allies and built on the credibility and trust of those allies.

Through our efforts in a number of communities, several models for outreach have emerged.

Single Staff Community Member Outreach/Services Model: This staff person is hired from the community as a generalist providing all core services. The staff person outreaches to the community and has credibility by being a community member. We used this approach in both the psychiatric disability community and the deaf/hard of hearing community. Part of the strength of this model is letting the staff person customize services in a way that meets community needs. The agency developed an initial framework and then hired staff and let them adjust the framework of service delivery in a way that met the community needs.

This model was able to produce some dramatic results through the system change efforts. Both programs generated effective access victories in their respective communities. There were significant changes in the mental health system locally and improvement of the emergency communication systems for consumers who are deaf.

However, there were some unique challenges. There were struggles around determining when staff issues were solved by accommodation versus training. Internally, there was tension between staff's individual disability identities and the ability to relate this to the issues of the larger disability community.

These issues were complicated and we were on new "turf" since we were dealing with populations that were not traditionally included in the movement. An example of this type of issue that has come up recently in the psychiatric program is that of forced institutionalization. Many in the movement recognize deinstitutionalization issues as important to our community. Often, however, these issues are not fought or prioritized when they arise for persons with psychiatric disabilities. In the deaf community there was a large struggle with the social isolation within our own center and this issue was a priority. One solution was including interpreter time for staff to meet informally with other staff.

Staff Liaison Model: In this model staff members act as a liaison between a single disability group and the center. Collaborative ventures support disability group efforts in unique ways and adapt our services to accommodate the special needs. The group has its own purpose and the liaison stays in touch with the group and communicates needs back to the agency. Examples include our work with the Environmental Illness/ Multiple Chemical Sensitivities Network and the Traumatic Brain Injury Group.

We were able to help with credibility for the environmental illness group since many settings did not consider EI a disability. We were able to provide our services in a safe environment, even if it meant meeting consumers at the beach in the fresh air. Inclusion in our literature, lists of disability types, using disability examples in presentations were valuable to the group in its work to get community recognition. For the traumatic brain injury group, the liaison set up a system to better coordinate services with other agencies providing consumers with services and advocating agency to agency for consumer choice in service delivery. From these collaborative activities, we generated an annual community fair for traumatic brain injury consumers with all services present. Consumers and families have access to "one-stop" where they can browse, meet staff, and check out their options. We avoid duplication and help consumers coordinate their services. We also have a peer support group led by a volunteer who is from the community.

Branch/Satellite Model: The branch/satellite approach creates a project around a distinct community. This approach was developed to reach the Latino community and the Chinese community. Cultural and language barriers justified a separate branch because they create as tough an obstacle to service provision as any geographic distance (in both cases consumers were also concentrated in their own neighborhoods). Bilingual, bicultural staff members were hired, working directly in the community. Both branch projects have a part-time outreach person focused on disability awareness and disability education, in addition to a full time person as a system advocate/generalist service provider. Services are partially out-stationed at an agency already accepted in the community (one of our key partners). This is both a convenience to the consumer as well as enhancement of our credibility by relying on the other agency's credibility in the community. Direct services, information and referral, outreach visits, targeted mailings, translation of ILRCSF brochures and other materials such as Fair Housing Act, ADA, SSI/SSDI booklets and information sheets, a separate phone line, and peer support were all done in other languages.

Our branches get regular publicity through staff-hosted columns and shows in the cultural media on disability issues. We have found it easier to get media coverage in these communities than in the so-called mainstream press. We have developed creative outreach strategies in these communities: a story book in Spanish about a Latino person with a disability who gets help through independent living services; presentations of a disability awareness puppet show to Latino elementary students; and a poster contest in the Chinese community (described below).

One Community's Experience: The Chinese Branch/Satellite

ILRCSF learned through trial and error. We used the same basic principles in each community, but, of necessity, the specific actions are reflective of each particular community. The need to work in the Chinese community came first from dawning awareness that we were serving a small number of Asian consumers in a city where roughly one-third of the population is Asian (largely Chinese). Herb Levine, program services coordinator, formed an alliance with several key social service people in the Chinese community. These allies knew a consumer with a visible disability who had experienced discrimination in the Chinese community and brought him in with several bilingual consumers from Chinatown. We started by calling a meeting together to talk about issues and concerns in the community for people with disabilities. The number one issue for the group was access to Chinatown; a community built on the famous hills of San Francisco. With ILRCSF's help, a group formed and began working on an agenda to make more places accessible. ILRCSF provided the expertise on access laws and the city structure to get things done.

The language barrier became a central one since not only many of the consumers but also other key people did not speak English. In the early days, meetings were in English with a Chinese translator. However, commitment to consumer leadership meant a shift. Only our staff didn't speak Chinese. The community members could not have meaningful charge of the group unless the meetings were in the native language of the community. Thus, it was a major accomplishment when the meetings switched to Chinese, with an English translator allowing our staff to participate. The meeting site was in a Chinatown location, central and familiar to the group. This was now their group and agenda. The result was a consumer group, Disabled People for an Accessible Chinatown, and community partners (Chinese for Affirmative Action and Chinatown Resource Center) working on community access through media and community disability awareness.

One of the first successful projects that grew from the meetings was a press conference about the lack of physical access in Chinatown. The story hit the front page of the Chinese Press. A result of the group efforts is increased access in Chinatown small businesses. One difficulty that consumers faced was that businesses would not wait on consumers with visible disabilities due to cultural views of disability being "bad luck."

A creative strategy focusing access in the forefront of the Chinese community evolved. Community members felt that there needed to be an on-going visual presence on disability to educate community members in a culturally-sensitive way. The idea for an annual poster contest, widely distributed in the community, is still being successfully used. In the Chinese community, disability is hidden, viewed as a responsibility of the family to take care of "its own." This project creates a visual reminder normalizing disability.

The annual poster contest challenges community "artists" to create a visual display. The winning choice is made into a poster widely distributed in the community. Prizes were given and a public ceremony gave visibility to the artists. Over time, the concept evolved into a calendar so as to increase the utility and likelihood of more widespread displays. After four years, the project has succeeded in bringing in both financial support and time from community members. A local member of the Board of Supervisors give out the prizes each year and participate in the awards ceremony. Supervisor Yee is not just a politician who shows his face at the event he is involved as a member of that community. This year, as a result of the partnership, ILRCSF and Supervisor Yee each recognized the other for their efforts.

This early community work also led to funding. A year or two later, ILRCSF created a Title VIIC funded branch/satellite to serve the Chinese community of San Francisco.

There were challenges to serving the community. It was important to have the language capability to respond to a consumer who called the agency. It was not enough to translate materials; the concepts do not always translate exactly, and there must be much discussion around terminology. There are great cultural differences among the Asian community, so we needed to be knowledgeable about the make-up of the San Francisco community. We needed to have staff that represented the group culturally to successfully reach the community. Cultural background is as important as speaking the language. To insure success, it is critical to know the community make-up before translating materials or hiring staff.

There are cultural values that have become a part of our work in this community. Due to the differing role of family in the Asian culture, we work with family members along with the consumer. It is important to include and educate family members in order to empower the consumer. Thus, our workshops are often filled with family members as well as consumers. Cultural competence means responding to issues of importance to the community. For example, issues like immigration are part of this community. Becoming a citizen is difficult, and until recently our local Immigration and Naturalization Service didn't know what reasonable accommodations were, let alone how to provide them. ILRCSF staff have tried to educate staff at INS and have advocated within that system, as well as with Social Security and the Department of Social Services, in order to secure appropriate services for the Asian community.

As with any new area, struggles and challenges require new strategies. One issue that has come out is recruiting staff members with the ability to understand both their culture and the independent living philosophy and blend the best of both into a culturally appropriate IL philosophy. Staff's written English language skills may be a problem. When English is a second language, information may not get communicated in other agency activities. Also, there are often different values that come up that may conflict with agency values and need to be discussed in an open dialogue. ILRCSF has experienced this around issues involving psychiatric disabilities, gender roles, cultural

and sexual orientation values. There are difficulties finding staff members since the pool is often small. There are sometimes competing loyalties between staff's loyalty to their community versus the larger disability community. They have to be able to identify with both communities to make the bridge successfully.

The process of bringing in new communities will change what you do in ways that you may not be able to anticipate. For example, since consumer empowerment is an issue, one way our organization gets feedback to insure quality services is to call consumers and ask follow-up questions. This practice was seen as conflicting with the cultural norms in the community and staff was concerned that the community would see this as a lack of trust in the staff member's work. Due to the cultural issues involved, it was an issue that the staff member had difficulty raising in supervision because of cultural perception that this would result in a loss of face. When the issue finally came up, a group brainstorming session developed strategies to get consumer feedback in a culturally sensitive way.

Some Necessary Ingredients

--Strong commitment to principles at the management level. Being inclusive while working in diverse communities will impact how the center operates in ways that are not possible to predict. Management must bring openness and flexibility into this endeavor. Getting the buy-in of the agency is important, i.e. board, staff, management, volunteers.

--Willingness to frame independent living philosophy in a way that is inclusive. Some definitions of the philosophy (especially early ones) by their nature eliminate both disability and cultural groups. The focus is on where to live rather than consumer choice and community participation. For example, describing the goal as living on your own focuses on individuals with physical disabilities and is not the way many cultures would choose to live. Describing the philosophy as centered around consumer choice and living up to a person's potential is more inclusive. As more and more groups become a part of the movement, this will evolve!

--Spirit of exploration and adventure! You will explore uncharted territory and sometimes your efforts will fail. You will try new things and they will not always work, but this may still result in bringing in new communities. Wonderful things, new energy and excitement will come into your center.

--Dedication to building meaningful relationships and trust in the community. This process takes time. Your agency must demonstrate that it understands enough of the issues so that persons coming in can trust that you will make your best efforts to serve them. Follow through is important. Your agency may need to examine its viewpoints around the difference between tolerance and inclusion. For consumers to have a sense of belonging at the center, there must be evidence that the center understands by demonstrating its inclusion. At ILRCSF, staff was shocked when an outcome of the

LesBIDis (Lesbian Bisexual Disabled women's group) was a suggestion that the agency participate in the local gay pride event. Some staff objected saying that we were not a gay agency; yet, this was never questioned when the agency participated in Chinese or Latino community events. The management staff was surprised at the reaction given the fact that the agency has some gay staff.

--Recognition that you can't wait for funding to hire staff members from every community. Community building can be done without staff members from every community. In some cases, successful organizing will lead to increased funding options. It is a recipe for failure to expect your staff to do more with the same resources, but you may use them differently or find and train volunteers. Commitment to diversity means that including all groups in the center's area is valued and becoming more representative reflects the center's values.

Conclusion

The key to diversity is making people feel welcome and included. The key to reaching a community is listening and incorporating what you learn. Inclusion of cross disabilities and cultures isn't really rocket science. Those of us committed to this movement already know something about this from our own experience. We all want people around who genuinely care about our needs without assumptions or taking over. We want full access, equal opportunities, and acceptance in the community with recognition of our contributions. We want to be welcomed in society, not just tolerated.

We can all be part of creating that kind of world!

About the Author

Carol Bradley's involvement in the independent living movement spans the last 10 years. She has been a volunteer, a board member, and a manager in centers for independent living and has served on the statewide independent living councils of two different states. For the past two years, she has served as the chair of the California Foundation for Independent Living Centers, the state association of centers. Carol developed a visual impairment during law school and subsequently practiced law in the areas of civil rights, employment, and labor. In addition to her CIL experience, she has been involved in advocacy and empowerment of disenfranchised groups in the legal system and as a manager/board member in grassroots organizations. Carol currently works as the development director of ILRCSF.

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Appendix B

Achieving Diversity at Independence, Inc.

by Susan Mikesic

October 2000

- Independence, Inc. in Lawrence, Kansas, is another of the Innovative CILs selected in our 2000 competition. When Independence, Inc. committed to making their center more culturally diverse, they realized that the first step to making their center a welcoming place for people of different cultures, disabilities and lifestyles was to educate staff.
- Through their educational activities, center staff came in contact with consumers, service providers, and others in the community who were members of minority groups. These contacts led to referrals, further contacts, and relationships that enhanced Independence, Inc.'s credibility in minority communities.

On August 11, 1992, Ed Roberts visited Independence, Inc., the center for independent living in Lawrence, Kansas, for an informal visit with our staff. Ed was in the area, having been invited as the keynote speaker at a conference on children and youth sponsored by Kansas State Social Rehabilitation Services. During his visit to our center, one of our staff members mentioned to Ed that she noticed a great lack of racial diversity at our midwestern regional conferences. She said that, in attending conferences and workshops, she would often look around and notice that she was one of only two or three people of color in a group consisting of hundreds of Caucasian people. She wanted to know, so she asked Ed, if this lack of diversity was everywhere in the disability rights community, or was it a problem only in the Midwest. Ed's answer was discouraging, but enlightening. He said that (at that time) a lack of racial diversity was a problem in the independent living movement everywhere. However, just when our staff member was about to react in a crest-fallen way, Ed looked her right in the eye and said, "So I guess you'll just have to do something about it, huh?" His comment to her, and to all of us, was a pivotal moment in the development of our Human Diversity Task Force. We realized at that moment, that, yes, it was time to do something.

We also began to examine ourselves in terms of the diversity of our staff, our board of directors, and the consumers of our services. We realized that we were not as diverse as we would like to be.

A Task Force is Formed

A group of staff members and consumers began to meet regularly with the goal of increasing the racial diversity of our consumers, our staff, and our board members. Originally, we called ourselves the Cultural Diversity Task Force, and set our goal to increase the cultural diversity of our staff, consumers, and board members. One of our original task force members described to us her experience being a woman of color

coming through our front door for the first time and encountering, in our staff, a sea of white faces. This was not comfortable for her. Stories like hers helped us to realize that we needed more diversity on our staff for consumers to feel more comfortable with us.

Then, a few of us attended a workshop hosted by our local battered women's shelter, on the topic of "Isms." The day-long workshop focused on racism, ageism, sexism, and homophobia. Those of us who attended this excellent presentation came away with renewed enthusiasm. We realized that we did not want to limit ourselves, and that we wanted to increase all aspects of multiculturalism at our center, including race, religion, gender, age, sexual orientation, socioeconomic status, and disability. At this point, we changed our name to the Human Diversity Task Force.

As we deliberated on how to market our services to underserved populations, one of our committee members commented that, if we wanted to communicate a welcome to diverse populations, we would need to know how to do so. In other words, we needed to begin by educating ourselves about diversity issues, so that we would know how to communicate caring and understanding to diverse groups when they did access our services. Therefore, we began a series of in-service trainings for our staff. We also sent out flyers and advertised these presentations in our agency newsletter, inviting consumers, colleagues, and the general public.

We immediately noticed that these talks not only provided us with quality training about diversity issues, but they also were effective in helping us market our services. What we originally thought of as a preparatory step before beginning our market efforts, actually became our marketing. For example, one of our early presentations was conducted by a panel of professors from Haskell Indian Nations University, a college in Lawrence exclusively for Native American students. We were not serving very many Native American consumers at the time, and we were pretty sure that some of the Haskell students had disabilities and could probably use our services. We decided to invite these professors, who were Native American themselves, to speak with us about their cultural beliefs and customs. In the month following that presentation, we received five new referrals from among Haskell students. One might envision the networking that led to these referrals: The professors we met probably took information about our services back to Haskell. They told their colleagues and their students about us, and those colleagues and students spoke to their associates and the word spread. In this grass-roots way, our reputation as a welcoming place was enhanced within this community of people. As a result, the Haskell students with disabilities who sought our services could approach us with some confidence that they would be treated with respect by us. In the years following, we found more and more opportunities to network with organizations that provide services for Native Americans in our community and now we often receive referrals from among this population.

The Human Diversity trainings work so well in this way, that we have continued them for the past seven years. Several times per year, we bring in speakers from a wide

assortment of backgrounds to teach us about their culture, their beliefs, their civil rights issues, and so forth. A sample of some of our topics follows:

- Consumers who use wheelchairs have described their trips abroad.
- International students from the University of Kansas have told us about their native countries.
- Gay, lesbian, and bisexual people have spoken about their lives and issues.
- Elders have spoken with us about aging issues.
- Holocaust survivors have described their experiences in the Holocaust.
- Women with disabilities who were abused or battered have shared their stories.
- Homeless people have spoken about their needs and their issues.
- A panel of deaf people has made suggestions for working with sign language interpreters.
- A panel of consumers with psychiatric disabilities has talked with us about their disabilities, made suggestions and given feedback to our staff.

The Human Diversity Task Force has sponsored other creative ventures. Every October, during the week of our annual agency Open House, we host a Human Diversity Potluck and encourage people to bring diversity topics to discuss. Sometimes we ask an outside facilitator to lead us in a discussion. Twice we chose the topic of Spiritual Diversity for our potluck event and encouraged people to bring sacred objects that illustrate their beliefs. People brought prayer beads, sacred books, pictures, and figurines.

During the event, we gave any interested person the opportunity to show their object to the group and speak about what their object means to them.

Twice we have invited people to bring "nostalgic" objects, items instilled with meaning for the person. People brought objects from their childhood, gifts from a beloved relative or friend, musical instruments and souvenirs from trips. Many people brought items that exhibited some aspect of their culture or their family of origin. Deep and personal sharing ensues as we celebrate our diversity in this very personal way. Some of the stories told during our Human Diversity potlucks have moved people to tears.

In 1998, we participated in the Season for Non-Violence, a grass-roots event commemorating the 30th anniversary of the passing of Martin Luther King, Jr., and the 50th anniversary of the passing of Gandhi. Community members were invited to host a public workshop on issues of non-violence. We hosted a public forum entitled, "Non-violent Social Activism," and our panel consisted of people from various areas of civil rights activism, including those working with women's issues, disability rights advocacy, issues of aging, and Native American concerns. Panel members spoke about ways that

they have non-violently acted to uphold civil rights and brainstormed about ways we could work together to become more of a political force through pooling our efforts.

For one of our early trainings, the Human Diversity Task Force invited a panel of individuals who are gay, lesbian or bisexual to speak with us about their lives and about issues they face. During this discussion, we asked the panel members how we could communicate a welcome to gay, lesbian, and bisexual citizens. They suggested that we hang Safe Zone Stickers in our windows and on our bulletin boards. These stickers, which feature an upside down pink triangle, a universal symbol of gay pride, indicate to visitors at our center that Independence, Inc. is a safe place for gay, lesbian, and bisexual people. Periodically, we host additional panel discussions and print articles in our monthly newsletter reminding our staff and visitors of the responsibilities involved in being a Safe Zone.

Twice a year we host a public talk that we call our Ability Awareness series. For each of these events, we choose a different disability and invite a panel of individuals who have that particular disability to speak about their experiences and about ways that the community could become more accommodating. We market these talks extensively and sometimes have 100 people in attendance. These events are opportunities for the community to learn about disability rights issues, and for consumers to give and receive support. Examples of the topics we have chosen for our Ability Awareness series include people with spinal cord injuries, people with psychiatric disabilities, people who are blind or sight impaired, people who are deaf or hard of hearing, people with multiple sclerosis, people with Fibromyalgia, adults with autism or Asperger's syndrome and adults with attention deficit disorder.

For the Ability Awareness talks, we sometimes focus on an issue that affects people with disabilities as a group, rather than focusing on a particular disability. These are our Ability Awareness Public Forums. Examples of topics we have focused on in this series include issues of homelessness and housing concerns and breaking down barriers to employment.

At any of these Ability Awareness events, the consumers chiefly run the show. The panel always consists of consumers. An Independence, Inc. staff member moderates the discussion, and one or more staff member might share briefly about our services, or speak about laws that protect the rights of people with disabilities. Also, we sometimes invite other community service providers to say a few words about their services. The primary speakers, however, are always consumers.

We have recently begun hosting Ability Awareness forums in small towns within the three-county area that we serve. These forums are part of our rural outreach that is designed to increase our service delivery in rural communities. We have made efforts to learn about the culture, customs, values, and preferences of the people from these rural

communities. For example, we learned not to hold a public meeting between the hours of four and six p.m. in these small towns, sometimes referred to as "bedroom communities." It is very common for citizens from these communities to commute to their jobs, and during late afternoon hours local residents prefer not to travel the busy and often dangerous rural highways unless absolutely necessary.

Once a year a small group of consumers and staff get together for our Annual Planning Meeting to brainstorm potential topics for future human diversity trainings. We usually show a video with a diversity theme at the meeting. We try to choose inspirational or interesting, thought provoking films, as we want to encourage people to attend and participate in this planning process. Our Human Diversity Task Force chair and her assistant (our peer counseling specialist) meet monthly to plan specific events, contact speakers and organize publicity. Very little time is involved in this simple process that produces very great benefit.

Very few of our speakers have asked for monetary compensation for their time in preparing and providing presentations. Out of more than 70 workshops, involving more than 100 speakers, only two people have asked for monetary compensation. Everyone else has donated his or her time and skills free-of-charge. We have found that when we approach people to ask them to speak and explained our purposes, we usually encounter an outpouring of generosity and support. As a result, the Human Diversity Task Force functions at Independence, Inc. with a very minimal budget--just a moderate amount for photocopying and mailing flyers to advertise our events.

Tracking Our Success

Since the inception of our Human Diversity Task Force in 1993, we have seen many changes at our center. We have more staff now, our budget has grown, we have several new programs, and two years ago we moved into a new building that we designed and built. During these seven years, we have reached some of our Human Diversity goals to increase the diversity of our staff, board and consumers, and some of our goals are yet to be attained.

The racial diversity of our staff has increased. In 1993, we had two staff persons who were non-white out of a total of 22 people, or nine percent. Currently, we have five staff members who are people of color, out of a total of 36, or 14 percent. (According to 1990 census information, the population of Douglas County, Kansas, where Independence, Inc. is located, is 89 percent Caucasian.)

We do not have a reliable source of statistical data on the ethnic diversity of our consumers. Our consumers are invited to disclose their ethnicity at the time of intake, but less than forty percent of consumers chose to do so in 1999. Of those who reported, sixty-eight percent were Caucasian and thirty-two percent were non-white. In order to gain a perspective on how the racial diversity of our consumers has changed

over the past several years, this author spoke with nine staff members who have worked at Independence, Inc. for at least six years. Five of these reported that they see more people of color now as compared with several years ago; the other four say the proportions seem about the same. One staff member interviewed has worked as a receptionist or back-up receptionist, which allowed him to observe firsthand the influx of our consumers. He reported that when he first began working in 1986, he estimated that about 2 percent of our consumers were non-white. Now, through observation, he estimates that about ten percent of our consumers are non-white.

According to staff observation, particularly in our benefits advocacy, housing advocacy, computer training, and payroll assistance programs, we are serving more non-white consumers now than six or seven years ago. Also, we are networking more often with other agencies that serve non-whites, particularly those that serve Haskell students and Native American citizens, and thereby receive referrals. We serve a substantial number of Russian and other international consumers, but we generally do not see many members of the Asian or Hispanic communities. The housing specialist reports working with several consumers who speak languages other than English, including Asian, Russian, and Spanish. According to staff observation, we are serving more African American consumers now than we were seven or more years ago.

Of course, we do not ask consumers about their sexual orientation, but we have had no consumer complaints due to homophobic behavior on the part of any member of our staff. Since 1993, we have been able to maintain our connection to the gay and lesbian community through engaging gay, lesbian, and bisexual individuals in our Human Diversity Task Force trainings and through courteous behavior on the part of our staff. We receive word-of-mouth referrals from the gay community and from our county AIDS project. It is common for consumers who are gay or lesbian to "come out" to our staff, perhaps prompted by the Safe Zone stickers we display.

We are serving more people who have disabilities that are considered traditionally underserved by CILs. Until the early 1990's, our center primarily provided services for wheelchair-users and other people with physical disabilities. In the early 1990's, we identified several disabilities as "underserved" and have increased our involvement with consumers from all of these disability groups over the past seven years. For example, looking at new consumer intakes for a calendar year, we initiated services for nearly three times as many people with head injuries, more than twice as many consumers with psychiatric disabilities, more than twice as many consumers with cognitive disabilities and a few more consumers with deafness or hearing loss in 1999 as compared with 1992.

We are also serving more consumers from rural communities, another group identified as "underserved." In 1999, we initiated services for more than twice as many consumers from rural communities, as compared with new consumers from these communities who initiated services in 1992. Our rural outreach efforts, in which the

Human Diversity Task Force plays a small part, have contributed to this growth. The racial diversity of our board has varied over the last seven years, with between ten and 25 percent being non-whites. Currently, ten percent of our board members are non-white, and we have six openings for new members. Our board is keenly aware of the need for more cultural diversity whenever choosing new members, so we look for this to increase over the next few months as these positions get filled. We are also hoping, as Human Diversity Task Force committee members, to solicit board involvement from among our colleagues at organizations that serve multicultural communities.

Your Center Can "Do Something About It", Too

All of this would be very easy for any center for independent living to duplicate. All you need is a small group of staff and/or consumers who believe in the value of increasing your center's diversity. If you would like to create a Human Diversity Task Force of your own, here are some suggestions for getting started:

First, get a committee together. Ask among your co-workers, consumers, and colleagues. Who is interested in addressing issues of human diversity at your center?

- Create a mailing list.
- Next, begin to meet regularly as a committee. Ask yourselves the following questions:
 - What are the human diversity demographics of your service area? Compare those statistics with the people you serve. Who is missing from your list of consumers?
 - Look at age, gender, race/ethnicity, religion, income level, and education level. Also, look for missing disability categories. Do you serve people who are deaf, blind, or deaf/blind, people with psychiatric disabilities, cognitive disabilities, learning disabilities, head injury, or seizure disorders?
 - Who do you know in your community who could help you? Look for:

Colleges/Universities
Multicultural Centers
Churches
Political Organizations
Civic Groups
Activists
Bilingual Newspapers
Bilingual Radio Stations
Support Groups
Coalitions

(Plan to use these venues for advertising educational workshops, staff and board positions announcements, and networking opportunities.)

- Are your center's policies and board policies supportive of diversity and intolerant of intolerance? Do items need to be added to the employee handbook or the agency by-laws, making this clear?
- Are any of your co-workers displaying signs of homophobia, racism or other 'ism's?
- Based on what you discover after asking these questions, develop a set of goals and a plan.

You might want to form committees to address each set of problems. For example, one committee could develop a series of staff trainings. Another committee could develop a proposal for agency policy supporting diversity. A third committee could develop a resource list of possible community collaborators. Be creative.

- Look for and begin attending workshops on diversity issues. Encourage staff to participate in continuing education on diversity topics. Get on mailing lists. Make announcements at your staff meetings about training opportunities.
- Solicit support from your board of directors and administrative staff. Submit proposals describing your plans. Encourage your executive director to mandate staff participation at human diversity in-service trainings. Invite board members to participate. Also, design some trainings specifically for your board.
- Build durability into your plan. Establish traditions. Host annual events. Choose a regularly scheduled time for planning meetings. Sponsor regular staff and community events.
- Get new staff members involved in human diversity issues. Develop an orientation that gives an overview of multiculturalism and guidelines for communicating a welcoming attitude.
- Keep your goals in mind and continue finding creative ways to work toward them.

The benefits of hosting Human Diversity trainings at your center are likely to be immeasurable. Presentations on human diversity topics are not only educational, but are often good fun. Your staff will provide better quality services to a wider variety of consumers. People with disabilities from underserved populations in your communities will get to know about your services and can gain from them. You will enhance your reputation as a welcoming agency. Your center, your consumers, and your community will benefit. Good luck to you on your human diversity journey.

About the Author

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Appendix C

DATA FROM 2000 704 REPORTS

Number of Part C funded CILs	281 ¹
Number of Part B & Part C Funded CILs	289
 DATA ON PART B & C FUNDED CILs	
Total Resources ²	\$315,137,780
Pass-through	\$120,710,812
Net Resources	\$194,426,968
Average Part C Funding level	\$162,565
 Percentage of Total Resource Funds	
Title VII ³	19%
Other Federal	7%
Other Government (state, local, etc)	48%
Private Funds	7%
Fee-for-Services	19%
 Consumers Served	 141,149
 Percentages in Age Groups	
< 6	2%
6 – 17	6%
18 – 22	7%
23 – 64	56%
> 65	24%
Unknown	4%
 Percentages in Gender	
Female	54%
Male	45%
Unknown	1%

¹ 15 CIL's Part C funded from 723 states.

² The raw data shows 6 CILs missing their funding.

³ Includes Part B, Part C and Chapter 2

Percentages in Race

American Indian/AK Native	2%
Asian	3%
Black	17%
Hispanic/Latino	10%
Native HI/Pacific Is	1%
White	66%
Unknown	1%

Percentages in Disability

Cognitive	11%
Mental/Emotional	11%
Physical	44%
Hearing	7%
Vision	6%
Sensory	1%
Multiple	17%
Unknown	3%

Consumer Achievements (Goals Met Top 4)

Self-Care	26,243
Communication	15,008
Other ⁴	13,564
Self-Advocacy	11,041

Top six services requested by Consumers (not including I&R services)

Personal Assistant Services	85,489
Skills Training	59,779
Advocacy	59,360
Peer Counseling	54,171
Housing/Home Modifications	36,645
Transportation	36,162

Information & Referral Requests 480,591

Number of people relocated from a nursing home	1,467
Number of people able to remain in their community	18,980

Community Change Achievements (Goals Met Top 3)

Barrier Removal	12,282
Housing Opportunities	3,322

⁴ Probably housing goals since the Housing (residential) Achievement is no longer an option.

Community Integration	2,588
Percentage in Community Services	
Community & Systems Advocacy	19%
Outreach	12%
Publications	7%
Education	13%
Registries	9%
Collaboration/Networking	12%
Other	28%
Percentages of CIL Staffing	
Staff with disabilities	67%
Staff from minority populations	25%

Appendix D

DEMOGRAPHIC DATA
ARIZONA CENTER FOR INDEPENDENT LIVING
704 Reports

	AZCIL#	AZCIL%	AZ Census (Approx.)
Age			
0-5yrs.	1	0%	7.5%
6-17yrs.	24	1%	22.2%
18-22yrs.	30	2%	7.2%
23-64yrs.	834	51%	50.4%
65+yrs.	696	43%	13.0%
unknown	39	2%	0.0%
Total	1624	100%	100.3%
Gender			
Female	1001	62%	50.1%
Male	623	38%	49.9%
Total	1624	100%	100.0%
Ethnicity			
Hisp/Latino	271	17%	25.3%
Not	1353	83%	63.8%
Total	1624	100%	89%
Race			
AI/AN	43	3%	5.0%
Asian	132	8%	1.8%
Black/AA	128	8%	3.1%
Hisp/Latino	271	17%	25.3%
NH/PI	5	4%	0.1%
White	1045	64%	75.5%
Total	1624	103%	110.8%
Disability		CILsNatn	
Cognitive	37	2%	11%
Mental/Emo	140	9%	11%
Physical	759	47%	44%
Hearing	5	0%	7%
Vision	27	2%	6%
Multiple	630	39%	17%
Other	26	2%	3%
Total	1624	100%	99%

Appendix E

US Census Bureau Quick Facts

People QuickFacts	Maricopa County	Arizona
Population, 2001 estimate	3,194,798	5,307,331
Population percent change, April 1, 2000-July 1, 2001	4.0%	3.4%
Population, 2000	3,072,149	5,130,632
Population, percent change, 1990 to 2000	44.8%	40.0%
Persons under 5 years old, percent, 2000	7.9%	7.5%
Persons under 18 years old, percent, 2000	27.0%	26.6%
Persons 65 years old and over, percent, 2000	11.7%	13.0%
Female persons, percent, 2000	50.0%	50.1%
White persons, percent, 2000 (a)	77.4%	75.5%
Black or African American persons, percent, 2000 (a)	3.7%	3.1%
American Indian and Alaska Native persons, percent, 2000 (a)	1.8%	5.0%
Asian persons, percent, 2000 (a)	2.2%	1.8%
Native Hawaiian and Other Pacific Islander, percent, 2000 (a)	0.1%	0.1%
Persons reporting some other race, percent, 2000 (a)	11.9%	11.6%
Persons reporting two or more races, percent, 2000	2.9%	2.9%
Persons of Hispanic or Latino origin, percent, 2000 (b)	24.8%	25.3%
White persons, not of Hispanic/Latino origin, percent, 2000	66.2%	63.8%
Living in same house in 1995 and 2000, pct age 5+, 2000	41.6%	44.3%
Foreign born persons, percent, 2000	14.4%	12.8%
Language other than English spoken at home, pct age 5+, 2000	24.1%	25.9%
High school graduates, percent of persons age 25+, 2000	82.5%	81.0%
Bachelor's degree or higher, pct of persons age 25+, 2000	25.9%	23.5%
Persons with a disability, age 5+, 2000	504,992	902,252
Mean travel time to work, workers age 16+(minutes), 2000	26.1	24.9
Housing units, 2000	1,250,231	2,189,189
Homeownership rate, 2000	67.5%	68.0%
Housing units in multi-unit structures, percent, 2000	26.6%	22.1%
Median value of owner-occupied housing units, 2000	\$129,200	\$121,300
Households, 2000	1,132,886	1,901,327
Persons per household, 2000	2.67	2.64
Median household money income, 1999	\$45,358	\$40,558
Per capita money income, 1999	\$22,251	\$20,275
Persons below poverty, percent, 1999	11.7%	13.9%

Appendix F

HISTORY OF INDEPENDENT LIVING

by

Gina McDonald and Mike Oxford

This account of the history of independent living stems from a philosophy which states that people with disabilities should have the same civil rights, options, and control over choices in their own lives as do people without disabilities.

The history of independent living is closely tied to the civil rights struggles of the 1950s and 1960s among African Americans. Basic issues--disgraceful treatment based on bigotry and erroneous stereotypes in housing, education, transportation, and employment--and the strategies and tactics are very similar. This history and its driving philosophy also have much in common with other political and social movements of the country in the late 1960s and early 1970s. There were at least five movements that influenced the disability rights movement.

Social Movements

The first social movement was deinstitutionalization, an attempt to move people, primarily those with developmental disabilities, out of institutions and back into their home communities. This movement was led by providers and parents of people with developmental disabilities and was based on the principle of "Normalization" developed by Wolf Wolfensberger, a sociologist from Canada. His theory was that people with developmental disabilities should live in the most "normal" setting possible if they were to be expected to behave "normally." Other changes occurred in nursing homes where young people with many types of disabilities were warehoused for lack of "better" alternatives (Wolfensberger, 1972).

The next movement to influence disability rights was the civil rights movement. Although people with disabilities were not included as a protected class under the Civil Rights Act, it was a reality that people could achieve rights, at least in law, as a class. Watching the courage of Rosa Parks as she defiantly rode in the front of a public bus, people with disabilities realized the more immediate challenge of even getting on the bus.

The "self-help" movement, which really began in the 1950s with the founding of Alcoholics Anonymous, came into its own in the 1970s. Many self-help books were published and support groups flourished. Self-help and peer support are recognized as key points in independent living philosophy. According to this tenet, people with similar disabilities are believed to be more likely to assist and to understand each other than individuals who do not share experience with similar disability.

Demedicalization was a movement that began to look at more holistic approaches to health care. There was a move toward “demystification” of the medical community. Thus, another cornerstone of independent living philosophy became the shift away from the authoritarian medical model to a paradigm of individual empowerment and responsibility for defining and meeting one’s own needs.

Consumerism, the last movement to be described here, was one in which consumers began to question product reliability and price. Ralph Nader was the most outspoken advocate for this movement, and his staff and followers came to be known as “Nader’s Raiders.” Perhaps most fundamental to independent living philosophy today is the idea of control by consumers of goods and services over the choices and options available to them.

The independent living paradigm, developed by Gerben DeJong in the late 1970s (DeJong, 1979), proposed a shift from the medical model to the independent living model. As with the movements described above, this theory located problems or “deficiencies” in the society, not the individual. People with disabilities no longer saw themselves as broken or sick, certainly not in need of repair. Issues such as social and attitudinal barriers were the real problems facing people with disabilities. The answers were to be found in changing and “fixing” society, not people with disabilities. Most important, decisions must be made by the individual, not by the medical or rehabilitation professional.

Using these principles, people began to view themselves as powerful and self-directed as opposed to passive victims, objects of charity, cripples, or not-whole. Disability began to be seen as a natural, not uncommon, experience in life; not a tragedy.

Independent Living

Ed Roberts is considered to be the “father of independent living.” Ed became disabled at the age of fourteen as a result of polio. After a period of denial in which he almost starved himself to death, Ed returned to school and received his high school diploma. He then wanted to go to college. The California Department of Rehabilitation initially rejected Ed’s application for financial assistance because it was decided that he was “too disabled to work.” He went public with his fight and within one week of doing so, was approved for financial aid by the state. Fifteen years after Ed’s initial rejection by the State of California as an individual who was “too” disabled, he became head of the California Department of Rehabilitation--the agency that had once written him off.

After Ed earned his associate’s degree at the College of San Mateo, he applied for admission to the University of California at Berkeley. After initial resistance on the part of the university, Ed was accepted. The university let him use the campus hospital as his dormitory because there was no accessible student housing (none of the residential

buildings could support the weight of Ed's 800-lb. iron lung). He received attendant services through a state program called "Aid to the Totally Disabled." This is a very important note because this was consumer-controlled personal assistance service. The attendants were hired, trained, and fired by Ed.

In 1970, Ed and other students with disabilities founded a disabled students' program on the Berkeley campus. His group was called the "Rolling Quads." Upon graduation, the "Quads" set their sights on the need for access beyond the University's walls.

Ed contacted Judy Heumann, another disability activist, in New York. He encouraged her to come to California, and along with other advocates, they started the first center for independent living in Berkeley. Although it started out as a "modest" apartment, it became the model for every such center in the country today. This new program rejected the medical model and focused on consumerism, peer support, advocacy for change, and independent living skills training.

In 1983, Ed, Judy, and Joan Leon, co-founded the World Institute on Disability (WID), an advocacy and research center promoting the rights of people with disabilities around the world. Ed Roberts died unexpectedly on March 14, 1995.

The early 1970s was a time of awakening for the disability rights movement in a related, but different way. As Ed Roberts and others were fighting for the rights of people with disabilities presumed to be forever "homebound" and were working to assure that participation in society, in school, in work, and at play was a realistic, proper, and achievable goal, others were coming to see how destructive and wrong the systematic institutionalization of people with disabilities could be. Inhuman and degrading treatment of people in state hospitals, schools, and other residential institutions such as nursing facilities were coming to light and the financial and social costs were beginning to be considered unacceptable. This awakening within the independent living movement was exemplified by another leading disability rights activist, Wade Blank.

ADAPT

Wade Blank began his lifelong struggle in civil rights activism with Dr. Martin Luther King, Jr. to Selma, Alabama. It was during this period that he learned about the stark oppression that occurred against people considered to be outside the "mainstream" of our "civilized" society. By 1971, Wade was working in a nursing facility, Heritage House, trying to improve the quality of life of some of the younger residents. These efforts, including taking some of the residents to a Grateful Dead concert, ultimately failed. Institutional services and living arrangements were at odds with the pursuit of personal liberties and life with dignity.

In 1974, Wade founded the Atlantis Community, a model for community-based, consumer-controlled, independent living. The Atlantis Community provided personal assistance services primarily under the control of the consumer within a community setting. The first consumers of the Atlantis Community were some of the young residents “freed” from Heritage House by Wade (after he had been fired). Initially, Wade provided personal assistance services to nine people by himself for no pay so that these individuals could integrate into society and live lives of liberty and dignity.

In 1978, Wade and Atlantis realized that access to public transportation was a necessity if people with disabilities were to live independently in the community. This was the year that American Disabled for Accessible Public Transit (ADAPT) was founded.

On July 5-6, 1978, Wade and nineteen disabled activists held a public transit bus “hostage” on the corner of Broadway and Colfax in Denver, Colorado. ADAPT eventually mushroomed into the nation’s first grassroots, disability rights, activist organization.

In the spring of 1990, the Secretary of Transportation, Sam Skinner, finally issued regulations mandating lifts on buses. These regulations implemented a law passed in 1970-the Urban Mass Transit Act-which required lifts on new buses. The transit industry had successfully blocked implementation of this part of the law for twenty years, until ADAPT changed their minds and the minds of the nation.

In 1990, after passage of the Americans With Disabilities Act (ADA), ADAPT shifted its vision toward a national system of community-based personal assistance services and the end of the apartheid-type system of segregating people with disabilities by imprisoning them in institutions against their will. The acronym ADAPT became “American Disabled for Attendant Programs Today.” The fight for a national policy of attendant services and the end of institutionalization continues to this day.

Wade Blank died on February 15, 1993, while unsuccessfully attempting to rescue his son from drowning in the ocean. Wade and Ed Roberts live on in many hearts and in the continuing struggle for the rights of people with disabilities.

These lives of these two leaders in the disability rights movement, Ed Roberts and Wade Blank, provide poignant examples of the modern history, philosophy, and evolution of independent living in the United States. To complete this rough sketch of the history of independent living, a look must be taken at the various pieces of legislation concerning the rights of people with disabilities, with a particular emphasis on the original “bible” of civil rights for people with disabilities, the Rehabilitation Act of 1973.

Civil Rights Laws

Before turning to the Rehabilitation Act, a chronological listing and brief description of important federal civil rights laws affecting people with disabilities is in order.

1964--Civil Rights Act: prohibits discrimination on the basis of race, religion, ethnicity, national origin, and creed; later, gender was added as a protected class.

1968--Architectural Barriers Act: prohibits architectural barriers in all federally owned or leased buildings.

1970--Urban Mass Transit Act: requires that all new mass transit vehicles be equipped with wheelchair lifts. As mentioned earlier, it was twenty years, primarily because of machinations of the American Public Transit Association (APTA), before the part of the law requiring wheelchair lifts was implemented.

1973--Rehabilitation Act: particularly Title V, Sections 501, 503, and 504, prohibits discrimination in federal programs and services and all other programs or services receiving federal funding.

1975--Developmental Disabilities Bill of Rights Act: among other things, establishes Protection and Advocacy services (P & A).

1975--Education of All Handicapped Children Act (PL 94-142): requires free, appropriate public education in the least restrictive environment possible for children with disabilities. This law is now called the Individuals with Disabilities Education Act (IDEA).

1978--Amendments to the Rehabilitation Act: provides for consumer-controlled centers for independent living.

1983--Amendments to the Rehabilitation Act: provides for the Client Assistance Program (CAP), an advocacy program for consumers of rehabilitation and independent living services.

1985--Mental Illness Bill of Rights Act: requires protection and advocacy services (P & A) for people with mental illness.

1988--Civil Rights Restoration Act: counteracts bad case law by clarifying Congress' original intention that under the Rehabilitation Act, discrimination in ANY program or service that is a part of an entity receiving federal funding--not just the part which actually and directly receives the funding--is illegal.

1988--Air Carrier Access Act: prohibits discrimination on the basis of disability in air travel and provides for equal access to air transportation services.

1988--Fair Housing Amendments Act: prohibits discrimination in housing against people with disabilities and families with children. Also provides for architectural accessibility of certain new housing units, renovation of existing units, and accessibility modifications at the renter's expense.

1990--Americans with Disabilities Act: provides comprehensive civil rights protection for people with disabilities; closely modeled after the Civil Rights Act and the Section 504 of Title V of the Rehabilitation Act and its regulations.

The modern history of civil rights for people with disabilities is three decades old. A key piece of this decades-long process is the story of how the Rehabilitation Act of 1973 was finally passed and then implemented. It is the story of the first organized disability rights protest.

The Rehabilitation Act of 1973

In 1972, Congress passed a rehabilitation bill that independent living activists cheered. President Richard Nixon's veto prevented this bill from becoming law. During the era of political activity at the end of the Vietnam War, Nixon's veto was not taken lying down by disability activists who launched fierce protests across the country. In New York City, early leader for disability rights, Judy Heumann, staged a sit-in on Madison Avenue with eighty other activists. Traffic was stopped. After a flood of angry letters and protests, in September 1973, Congress overrode Nixon's veto and the Rehabilitation Act of 1973 finally became law. Passage of this pivotal law was the beginning of the ongoing fight for implementation and revision of the law according to the vision of independent living advocates and disability rights activists.

Key language in the Rehabilitation Act, found in Section 504 of Title V, states that:

No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Advocates realized that this new law would need regulations in order to be implemented and enforced. By 1977, Presidents Nixon and Ford had come and gone. Jimmy Carter had become president and had appointed Joseph Califano his Secretary of Health, Education, and Welfare (HEW). Califano refused to issue regulations and was given an ultimatum and deadline of April 4, 1977. April 4 went by with no regulations and no word from Califano.

On April 5, demonstrations by people with disabilities took place in ten cities across the country. By the end of the day, demonstrations in nine cities were over. In one city, San Francisco, protesters refused to disband.

Demonstrators, more than 150 people with disabilities, had taken over the federal office building and refused to leave. They stayed until May 1. Califano had issued regulations by April 28, but the protesters stayed until they had reviewed the regulations and approved of them.

The lesson is a fairly simple one. As Martin Luther King said,

It is a historical fact that the privileged groups seldom give up their privileges voluntarily. Individuals may see the moral light and voluntarily give up their unjust posture, but, as we are reminded, groups tend to be more immoral than individuals. We know, through painful experience that freedom is never voluntarily given by the oppressor, it must be demanded by the oppressed.

Leaders in the Independent Living Movement

The history of the independent living movement is not complete without mention of some other leaders who continue to make substantial contributions to the movement and to the rights and empowerment of people with disabilities.

- Max Starkloff, Charlie Carr, and Marca Bristo founded the National Council on Independent Living (NCIL) in 1983. NCIL is one of the only national organizations that is consumer-controlled and promotes the rights and empowerment of people with disabilities.
- Justin Dart played a prominent role in the fight for passage of the Americans with Disabilities Act, and is seen by many as the spiritual leader of the movement today.
- Lex Frieden is co-founder of ILRU Program. As director of the National Council on Disability, he directed preparation of the original ADA legislation and its introduction in Congress.
- Liz Savage and Pat Wright are considered to be the “mothers of the ADA.” They led the consumer fight for the passage of the ADA.

There are countless other people who have and continue to make substantial contributions to the independent living movement.

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Appendix G

“Outreach Made Simple”

Purpose of Training

Identify successful outreach approaches
Develop strategies
Implement a plan
Evaluate the effectiveness

Four Key Elements

Who are we serving: Identifying Populations

What do we know: Understanding Cultures

How does your Center look externally: PR, Marketing and Networking

How does your Center look internally: Staff and Board Planning

Who are we serving?

Identifying Populations

UNREPRESENTED AND
UNDERREPRESENTED

Know the demographics of your service area

DEMOGRAPHICS

- Age
- Gender
- Racial and Ethnic background
- Disability
- Residential status
- Socioeconomic status
- Urban vs. Rural
- Religion/Faith Groups
- Sexual Orientation

Community Resources and Needs Assessment

- Housing
- Transportation
- Employment
- Education
- Natural Community Supports (for example):
- Respite, Personal Assistant Services, ASL, TTY
- Accessible Retail Stores
- Accessible Recreation
- Peer Mentoring Programs

- Youth Leadership Conferences/Activities
- Aging Leadership/Activities
- Public Services/Facilities
- Social Services

What organizations, programs, and services are already available?

Do they promote the independent living philosophy? Are people satisfied? Why/why not? What are the key issues to address? How do you know what they are?

Who is not being served and why?

- Census Bureau, CIL 704 Report-demographic page, Bureau of Vital Statistics
- Chamber of Commerce

Potential Sources for Finding Information

- Census Bureau
- CIL 704 Report-demographic page
- Bureau of Vital Statistics
- Chamber of Commerce
- City and County Planning Departments
- Community Action Centers
- Local College and University libraries
- United Way
- Public Housing Authorities
- Urban Leagues
- NAACP
- Others
- **Local Sources:**
 - Telephone and Service Directories
 - Libraries
 - Community Colleges and Universities
 - City and County Planning
 - Local Ethnic and Service Organizations
- **State Sources:**
 - Rehabilitation Services
 - Statewide Independent Living Councils
 - Assistive Technology Projects
 - Disability/Advocacy Councils and Organizations

- **National sources:**
 - Independent Living Research Units
 - National Council on Independent Living
 - Census Bureau – www.census.gov
 - National Council on Disability
 - National Organization on Disability

Please Keep this in Mind

Definitions of disability must be clear and specific. Don't assume that your definition of "disability," "deaf," or "blind" is identical to the definition used in a study.

What do we know?

Understanding Cultures and Needs

Know and Respect Cultural Differences

- Know and respect cultural differences
- Not all cultures understand or accept the IL philosophy
- One cannot make assumptions about groups
- Collect information in a way that is open

We must find solution to these questions

How do we demonstrate community support for those needs?

How can CILs adjust their programs to meet those needs?

Ideas to incorporate in the planning process for effective outreach

- Respect cultural language, traditions, beliefs and spiritual perspective of the target population
- Consider the social and economic climate
- Do not stereotype cultures
- Knowledge the issues and priorities
- Know the leaders and key players

Know Your Communities:

- a) Identify bilingual and bicultural partners
- b) Gather reliable information:
 - Conduct focus groups
 - Conduct interviews
 - Conduct mail or telephone surveys
 - Assess CIL information and referral data

- c) Develop a list of issues or information
- d) Use target group to train staff and board

Build Partnerships

- a) Invest in the community
- b) Work with organizations that serve targeted populations
 - Understand their programs
 - Make sure CIL services are complimentary
- c) Recruit board and staff that reflect community
- d) Assure board and staff are community leaders

How does your CIL look externally?

Marketing and Public Relations

- Incorporate community issues into your Strategic Plan
- Develop a public relations campaign
- Create outreach materials targeting needs of specific groups

Accessible Materials to All

Printed information:

- Write at a reading level that is easy to understand
- Avoid acronyms and “professional phrases” that are not easily understood
- Use language that can be understood
- Accessible in a variety of formats: Braille, large print, tape, and disk.
- Qualified persons should edit and proof
- Monitor the effectiveness of your Public Relations

Monitor the effectiveness of your Public Relations

- Get feedback
- Make staff available to communicate
- Develop process to address language and cultural issues

Getting Information Out

- Train Board and staff
- Designate a lead person
- Maintain current list of media contacts
- Develop relationships with local media
- Respond to issues in editorials and opinion pages
- Create a media package
- Build a public and community history

Information should be accurate and cost-effective

Enhancing Your Public Relation Strategies

- Create opportunities through radio, TV, and newspapers on a regular basis
- Utilize existing mailings
- Develop partnerships (local college interns)
- Respond to hot issues

Create Opportunities

- Regular information magazines
- Public television programs
- Column in a local newspaper or newsletter
- Use your own calendars and newsletters

Getting the Word Out

- Network with other agencies
- Provide website updates and e-alerts
- Produce a disability issues program on public TV or radio
- Locate good, generic videos
- Write a grant to produce a video
- Expand partnerships by getting consumers on Boards and Commissions
- Set up videoconferences with others
- Use list serves and group emails
- Contact an advertising club for donated time

How does your CIL look internally?

Board and Planning

Board and Staff Outreach Strategies

“Operate in a manner that is sensitive to and respectful of ethnic, and disability culture”

...Recruit qualified staff and board.

...Create and maintain linkages

...Conduct cross-cultural sensitivity activities

... Develop cross training

Outreach Planning

Who do we outreach to?

What do we know?

Where do we start?

When should we start?

How will we evaluate it?

Outcomes
Cost
Satisfaction level

Implementation and Evaluation

Implement an outreach action plan

- Target a specific group or community
- Assign a team with a leader
- Collect and review information about the group
- Develop a timeline
- Develop a budget if needed

Evaluating Outreach Effectiveness

Formative Evaluation

- Series of activities to improve outreach
- Have an expert review and comment on your plan
- Make changes in the plan based on new data
- Try a small scale outreach effort
- Revise according to feedback

Process Evaluation

How successful was the outreach design?

- Takes place during and after implementation
- Gather an outreach evaluation (one page)
- Make changes based on feedback and interviews

Outcome Evaluation

Measure the impact and people who have benefited

- Review data collected in the 704 reports
- Calculate a cost benefit analysis
- Evaluate success based on satisfaction level of new persons reached

Analysis

- Who do we provide outreach to?
- What do we know about the population?
- Where do we start implementing it?
- When should this process be started/completed?
- How will we evaluate or know if we succeeded?
- When completed: What outcomes will be measured?
 - What are the cost benefits?
 - What is the satisfaction level of consumers?