THE STATEWIDE INDEPENDENT LIVING COUNCIL OF ILLINOIS

"*When You Go Visiting & Invite the Company Home!*"

Center for Independent Living: Outreach Planning Manual

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Preface:

Statewide Independent Living Council of Illinois Study:

The 1995 Illinois Independent Living Services Capacity/Needs Assessment commissioned by the Statewide Independent Living Council of Illinois (SILC) indicated that Illinois Centers for Independent Living (CILs) are often under-funded and overwhelmed with community demands on their resources and time. In addition, CILs reported only nominal success using formally structured outreach plans. Most CILs rely on their networks with local organizations and their work with local consumers to keep them up-to-date on the needs of their communities. Many CILs indicated they would like information on how to maximize the effectiveness of their outreach efforts to unserved and underserved populations in their service delivery area.

The need to increase outreach was identified by the 1995 SILC study and was included as part of the Illinois State Plan for Independent Living Services and Centers for Independent Living: 1996-1998 (SPIL). Members of SILC voted to develop an Outreach Planning Manual that would help Illinois CILs increase the effectiveness of their outreach activities. This manual will provide CILs with the basic information necessary in developing, implementing, and evaluating outreach efforts.

1992 Amendments to the Rehabilitation Act:

A Rehabilitation Act finding supports the need to promote outreach. In Section 21 of the 1992 Amendments to the Rehabilitation Act of 1973, Congress found that:

Changing Racial Profile:

"The racial profile of America is rapidly changing. While the rate of increase for white Americans is 3.2 percent, the rate of increase for racial and ethnic minorities is much higher: 38.6 percent for Latinos, 14.6 percent for African-Americans, and 40.1 percent for Asian Americans and other ethnic groups. By the year 2000, the Nation will have 260,000,000 people, one of every three of whom will be either African-American, Asian-American or Latino."

Rate of Disability:

"Ethnic and racial minorities tend to have disabling conditions at a disproportionately higher rate. The work-related disability for American Indians is about one and one half times that of the general population. African-Americans are also one and one half times more likely to be disabled than whites and twice as likely to be severely disabled."

Inequitable Treatment:

"Patterns of inequitable treatment of minorities have been documented in all major junctures of the vocational rehabilitation process. As compared to white Americans, a larger percentage of African-American applicants to the vocational rehabilitation system are denied acceptance. Of applicants accepted for service, a larger percentage of African-American cases are closed without being rehabilitated. Minorities are provided less training than their white counter parts. Consistently, less money is spent on minorities than their white counter parts."

Title VII- CIL Requirement:

"In awarding grants, contracts, or cooperative agreements under titles I, II, III, VI, VII, and VIII, and section 509, the [Rehabilitation Services Administration] Commissioner and the Director of the National Institute on Disability and Research, where appropriate, shall require applicants to demonstrate how they
will address, in whole or in part, the needs of individuals from minority backgrounds."

SILC Outreach Committee:

In the summer of 1996, the SILC Outreach Committee put together an ad-hoc work group composed of staff from Illinois CILs and statewide minority organizations to develop an Outreach Planning Manual. During 1996 and 1997, the work group met on numerous occasions, and via conference calls, to develop a comprehensive document that will help CILs implement outreach activities to reach unserved and underserved populations in their service area. In 1998, a handful of original participants developed regional CIL training and made final changes to this manual.

Purpose:

The purpose of this manual is to give Center for Independent Living (CIL) staff and boards ideas on how they might develop, implement and evaluate effective outreach efforts. It has been designed to be flexible in order to meet the unique needs of each CIL and the many neighborhoods and communities in their service area. It is the intention of the SILC Outreach Committee to provide a manual that covers a comprehensive range in which each CIL will find information that is helpful to improving their local outreach efforts. The manual will help CILs tailor their outreach activities to met the needs of their community.

Who Should Use This Manual?:

This manual is intended to provide useful information for staff members as well as board members by providing ideas and examples of how CILs can enhance their ability to reach unserved and underserved populations. With increasing state and federal emphasis on outcomes, this document will assist CILs in developing an outreach plan that can be applied. This manual will help to increase the likelihood that CIL board composition and consumer service demographics will reflect their service area. This manual is meant to be a tool to help CILs work smarter, not harder.

Terms used in this Manual:

1. **Traditionally Unserved and Underserved Populations**:

In your service area this might include one or more of the following:

Age:
Both seniors and children.

Gender:
Males and females tend to be equally unrepresented.

Racial and Ethnic:
African Americans, Asian Americans, Latinos, and Native Americans.

Disability:
Persons with hearing, visual, cognitive, developmental, psychological disabilities, and multiple chemical sensitivities.

Institutions:
Persons who live in developmental disability institutions, nursing facilities, group homes, retirement communities, rehabilitation units, hospice and other congregate settings.

Socio-economic status:
Persons living in economically depressed areas.

Geography:
Most of Illinois is rural. Many rural areas do not have a Center for Independent Living. In addition, statistics indicate that 74 percent of the individuals currently receiving direct services by an existing CIL, are people who live in the county where their CIL is located.

Other groups:
Some unserved and underserved groups may have a higher than average representation in a service area. For example, persons in rehabilitation facilities, workshops, and persons in retirement communities.

The demographic and geographic profile of each Center for Independent Living will be unique. The potential population of persons who could benefit from CIL services and activities can be complex because individuals and their families may fall into one or more of the demographic and geographic categories cited above.

2. **Ethnic Groups:**

Of or relating to large groups of people classed according to common racial, national, tribal, religious, linguistic, cultural origin or background.

3. **Bicultural:**

Someone who is of two cultures, as well as, may have the ability to read and/or speak two languages.

4. **Latino**:

Anyone whose ancestry derives from a Latin country (e.g., Mexico, Puerto Rico, Columbia, Brazil).

5. **National Disability Organizations:**

Independent Living Research Utilization Project (ILRU).
National Council on Independent Living (NCIL).
National Council on Disability (NCD).
National Center for Latinos with Disabilities (NCLD).

The History of Independent Living [and Civil Rights Movements]:

Gina McDonald and Mike Oxford
(reprinted with permission)

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 as possible if they were to 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-Ib. 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 a 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. in Selma, Alabama. It was during this period that he learned about the stark oppression which 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 Americans 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 “Americans 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 [psychological disabilities].

1988-- Civil Rights Restoration Act: counteracts bad case law by clarifying Congress' original intention that under the Rehabilitation Act, that 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 Section 504 of Title V of the Rehabilitation Act and its regulations.

The modem 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 8, 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 an 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 grow more immoral than individuals. We know, through painful experiences 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 1988. 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.

REFERENCES

DeJong, Gerben. "Independent Living: From Social Movement to Analytic Paradigm," Archives of Physical Management and Rehabilitation: 60, October, 1979.

Wolfensberger, Wolf. The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation, 1972.

Five (5)Elements of Effective Outreach:

I. Identifying the Unserved and Underserved:

II. Understanding Cultures and Needs:

III. Marketing and Public Relations:

IV. Staff and Board Outreach Planning:

V. Eliminating Service Barriers:

I. IDENTIFYING THE UNSERVED AND UNDERSERVED:

Identifying the demographics in your service area is the first priority. All of your planning for outreach activities will depend on the racial, ethnic, disability, age, gender, socio-economic status, and geography profile of your service area.

1. What is the Demographic and Geographic Profile of the Targeted Group in Respect to?:

    a) Age.
    b) Gender.
    c) Racial and Ethnic background.
    d) Disability: physical, hearing, visual, cognitive, developmental disabilities, multiple chemical sensitivities, and others.
    e) Residential status: large/small institutions, nursing homes, hospice, with family/friends, independent (with/without support services).
    f) Socio-economic status.
    g) Proximity to population centers.
    h) Other groups with a higher than average representation in a service area, (e.g., persons in rehabilitation facilities, workshops, retirement communities, and the like.

2. Community Resources and Needs Assessment:

    a) A needs assessment should be conducted. Following is a list of possible issues that might be explored:

        i) Affordable and Accessible Housing.
        ii) Affordable and Accessible Transportation.
        iii) Mainstreamed Employment Opportunities.
        iv) Mainstreamed Educational Opportunities.

v) Natural Community Supports (for example):
*Personal Assistant Services.
*ASL Interpreters.
*TTY Access in public agencies.
*TTY Access in businesses.
* Alternate format (Braille, tape, disk, etc.) in public agencies.
*Alternate format (Braille, tape, disk, etc.) in businesses.
*Respite Services.

vi) Affordable and Accessible Retail Stores.

vii) Affordable and Accessible Recreation.

viii) Accessible public services and facilities.

b) What organizations, programs, and services are already available?

i) Do these organizations and services promote the independent living philosophy?

ii) Are people satisfied? Why/why not?

iii) What are the key issues that persons with disabilities would like to address?

c) Based on the demographic profile, who is not being served?

i) Why?

ii) What are the barriers (environmental, geographic, attitudinal, skills, knowledge) that must be addressed?

iii) What local organizations might support CIL activities? What local organization might resist CIL activities?

3. Potential Sources for Finding Information (may include):

a) Bureau of the Census.
b) Bureau of Vital Statistics.
c) Chamber of Commerce.
d) City and County Planning Departments.
e) Community Action Centers.
f) Local College and University libraries.
g) United Way.
h) Public Housing Authorities.
i) Urban Leagues.
j) NAACP.
k) Others

4. How to Get Information:

Many organizations who focus on issues related to persons with disabilities, as well as organizations who do not focus specifically on disability issues may have data that can assist your Center for Independent Living. They include local, State and National sources.

a) Basic local research:

i) Utilize telephone and service directories.
ii) Libraries.
iii) Community Colleges and Universities.
iv) City and County Planning Departments.
v) Local ethnic organizations.
vi) Local service organizations.

b) State sources (may include):

i) State library.
ii) Department of Human Services, Rehabilitation Services.
iii) Statewide Independent Living Council.
iv) Coalition of Citizens with Disabilities in Illinois.
v) Illinois Assistive Technology Project.
vi) Other disability and advocacy councils and organizations.

c) National sources:

There are some national sources who collect and keep demographic information, including:
i) Independent Living Research Unit.
ii) National Council on Independent Living.
iii) National Council on Disability.

NOTE: For reasons of accuracy, 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 African-American, and a local Chamber of Commerce study finds that 18 percent of African-Americans 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 different samples of the population.

Citing the population and unemployment percentages from both the United Way and the Chamber of Commerce can support the need for a CIL and is perfectly reasonable as long as you do not assume a connection between the two percentages.

II. UNDERSTANDING CULTURES AND NEEDS:

1. Know and Respect Cultural Differences:

Gathering statistical information is only the first step to outreach. 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 (CILs). Therefore, one can not assume the target group needs, wants, or can access the CIL's current services. The most important goal is to collect information from unserved and underserved groups in a way that is open to understanding and respecting the cultural context of their needs.

We must learn:

- **What are the needs?**
- **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.

The planning process must respect and incorporate the cultural language, traditions, beliefs and spiritual perspective of the target population. An understanding 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 a knowledge of the community and their issues and priorities. It is important to know the leaders and key players to help provide effective outreach.

2. 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:

      i) Conduct focus groups.
      ii) Conduct interviews.
      iii) Conduct mail or telephone surveys.
      iv) Assess CIL information and referral data.

   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 all staff and board utilizing representatives of unserved and underserved populations.

3. 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 unserved and underserved populations to:

      i) Understand their programs and services.
      ii) Find ways to have CIL services compliment their services.

c) There should be representation on the CIL board and staff of qualified individuals from unserved or underserved populations and communities.

d) Recommend potential leaders with disability to serve on other organization's boards and committees.

III. MARKETING AND PUBLIC RELATIONS:

Utilize the needs and issues identified of the targeted population and incorporate these issues into the Center for Independent Living's (CILs) Strategic Plan. Based on the feedback, develop a public relations campaign using the information and suggestions gathered.

■ Create outreach materials which target the needs of a specific population segment.

■ Create materials which identify common issues that cut across all potential CIL consumers.

■ Communication is developed in a way that is accessible to the target group. All 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?).
- Be written in a language that can be understood (i.e., everyday Spanish, not necessarily the courses they taught in school).
- Be accessible in a variety of formats; Braille, large print, tape and disk.
- Be provided in Spanish and English when targeting the Latino community.
- Identify qualified persons who can edit and proof materials in Spanish, Chinese, or other languages.

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

If you provide information in another language, ensure staff is readily available to communicate effectively. There should also be a process in place to address language issues.

1. Working with the General Public:

Develop and implement a strategy to get information to the general public in a CIL service area that is accurate and cost-effective.

a) Public Relations Strategy:
Create a media package which clearly identifies the CIL's mission, services and programs. You should also develop a plan. The media package should clearly understand and articulate the mission, services, and activities of your CIL.

The plan should include:

i) Training for board and staff to interact with media .
ii) Designate a lead person to provide public information.
iii) Develop and maintain personnel relationships with local media people (reporters, staff, public and private individuals who may have access to the media).
iv) Make sure that the CIL reacts to issues that affect people with disabilities.

Keep copies of press releases, newspaper articles, televisions and radio spots. These will help build a community history of your organization and gives you feedback on better ways to get the word out.

b) Enhancing Your Public Relation Strategies:

i) Respond to issues which are hot or controversial in the local media. Include issues which affect unserved and underserved populations before you attempt to address the independent living issues. This will allow you a greater opportunity to gain your targeted communities trust.

ii) Look for opportunities to utilize existing mailings, (i.e: banks, utility companies, Chamber of Commerce and other organizations).

iii) Look for creative ways to 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) for your CIL.

iv) Create opportunities through radio, TV, and newspapers on a regular basis. For example:

1) Regular disability information segments (on a local television magazine show or local radio program).

2) A regular disability program on public television.

3) A regular column in a local newspaper or newsletter.

4) CILs could also use their own monthly calendars and newsletters to share information.

5) 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.

6) Establish a link with an organization to produce a disability issues program on public television or radio.

v) Conduct research to locate good, generic videos (short commercials or 30 minute cable programs) on what a Center for Independent Living does. Review and select a video for possible distribution to local television and cable stations.

vi) Research the possibility of having a foundation underwrite the cost of purchasing or producing a generic video for Illinois CILs (something CILs could get aired locally, that would identify their center by name, address and phone number).

IV. STAFF AND BOARD OUTREACH PLANNING:

The Center for Independent Living (CIL) should operate in a manner which is sensitive to and respectful of ethnic and disability culture.

1. Actively recruit qualified staff and board who represent ethnic and disability demographics, as well as promote the independent living philosophy. Recruit qualified staff and board by creating and maintaining linkages in target populations for present and future staff needs.

2. Annually conduct activities that enhance cross cultural sensitivity. Develop cross training with other organizations and agencies.

    a) Organize a committee to develop a training model and schedule that would enable you to send out proposals to consultants.

    b) Request that staff, board, consumers and agency contacts assist in identifying consultants and trainers.

    c) Designate resources to conduct training.

V. ELIMINATING SERVICE BARRIERS:

A major barrier to connecting persons with disabilities and the services and activities Centers for Independent Living (CIL) offer is due to geography and transportation.

1. Identify Affordable, Accessible Transportation:

   If public transportation is available:

   a) The CIL could collect and disseminate a directory of transportation services currently available in their service area by contacting local and state entities to identify who they serve and what type of services are available.

      Local resources could include:
      i) Disability service programs.
      ii) Senior programs.
      iii) County, and city transportation officials.
      iv) Consumer organizations.

   b) Distribute existing transportation directories.

   c) Participate in local transportation boards.

   d) Assume an advocacy role for adequate, accessible, affordable transportation within the service area.

2. Building Bridges to Your Consumers:

While it may not always be possible for a consumer to get to a Center, here are some possible solutions:

a) Allocate sufficient resources in budget for travel.

b) Link with local entities, such as social service organizations, consumer groups, health care agencies, in collecting and sharing information about programs and services.

c) Establish a policy for consumers to call free (e.g., toll-free line, collect calls), asking staff to return their call.

d) Establish satellite offices or telephone numbers at local community organizations, churches, service clubs, consumer groups, and the like.

e) Be creative in coordinating services with consumers in various locations, (e.g., malls, parks, or where the consumer is comfortable).

f) As resources allow, set-up video-conferences.

g) If consumers have computers, the CIL might investigate:
   i) Sharing information on the Internet.
   ii) Using e-mail.
   iii) Establishing Web sites and chat rooms.
   iv) Researching ways to obtain computers and technical support to persons with disabilities.

Implementation and Evaluation:

After the staff or board of a Center for Independent Living (CIL) consider the five 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 unserved or underserved group. Adaptations of Crimando and Riggar (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. For example:

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 unserved or underserved persons with disabilities who have benefitted.

i) Review data collected from 704 Reports to verify increased outreach efforts to a previously unserved or underserved group (e.g., disability group, minority group, 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.

References:

Crimando, W. & Riggar, T. F. (1988). Handbook for in-service training in human services. Southern Illinois University Press.

McDonald, G. & Oxford, M. The history of independent living.

Rehabilitation Act of 1973, 1992 Amendments: Section 21.