University of
Connecticut

A.J. Pappanikou Center for Developmental Disabilities
A University Center for Excellence in Developmental Disabilities Education, Research and Service

September 2005

Connecticut Real Choice Consumer Survey

Are citizens with disabilities able to participate in all desired aspects of community life in the town in which they live?

Dale Borman Fink, Ph.D.
Christine M. Gaynor, M.A., *Project Coordinator*
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INTRODUCTION

The Real Choice System Change Community Inclusion Assessment was launched "to determine the level and quality of inclusion in Connecticut communities." By recruiting consumers with disabilities and their families from communities all over the state to answer our survey questions, we hoped to have valuable information that would help us to work toward the first overall goal of the project; namely, "to build the capacity within the State of Connecticut to support informed decision-making, independent living, and a meaningful quality of life for persons with disabilities across the lifespan."

CONTENTS OF THE SURVEY

Our survey consisted of eight sections. The first section addressed demographics, including the city or town in which the respondent lived, his or her ethnicity, age, gender, and disability type. The second section was geared only to those attending kindergarten through high school programs and concerned their experiences in school. The remaining six sections asked about employment, accessibility of commonplace community venues, use of transportation, voting, degree of community participation, and feelings about community participation.

We adapted the sections of our survey addressing employment, degree of community participation, and feelings about community participation from a national survey on "Community Participation" conducted by the widely recognized polling firm, Harris Interactive, in partnership with the National Organization on Disability (N.O.D.). This survey queried national samples of American adults with and without disabilities in 2000.

In addition to the Community Participation Survey, Harris Interactive has conducted a "Gaps Survey" every four years beginning in 1986, collecting data on ten topics that they have identified as indicators of the quality of life and standard of living of Americans with disabilities:

employment, income, education, health care, transportation, entertainment/going out, socializing, attendance at religious services, political participation, and life satisfaction. With these data in hand, they profile the gaps between the lives of Americans who have disabilities and those who do not. We drew from the Gaps Survey (Harris Interactive, 2000 and 2004) for some of our comparisons. Each time this report mentions data from a Harris survey, a footnote clarifies which survey we are citing.

HOW WE OBTAINED OUR SAMPLE

We used the "shotgun" method to find respondents, sending out correspondence by every channel we could find. We asked persons with disabilities to either contact the A. J. Pappanikou Center to schedule a telephone interview or to go on-line to answer the questions. In addition, we requested that family members, advocates, partners, and friends fill out the survey on behalf of children or adults who would not otherwise be able to respond. In discussing survey respondents, we refer to persons with disabilities who either responded on their own or had someone respond for them. We do not consider the parents, partners, or advocates who filled out surveys or answered the telephone questions as respondents but as intermediaries.

We collected a total of 250 completed surveys. Two-thirds (167) completed the survey by telephone and one-third (83) on-line. As for how they had become aware of the survey, more than one in five of the respondents (54) mentioned a mailing from the Department of Social Services as the means by which they learned about it. An even larger number (74) reported they got word of the survey from a disability network, such as an autism support group, an Independent Living Center, or a special education advocacy group. The remainder mentioned learning about the survey from e-mails, newsletters, and flyers, but without specifying further details. We believe that most of these were also associated with disability networks of one kind or another.

COMPOSITION OF THE SAMPLE

AGES OF RESPONDENTS

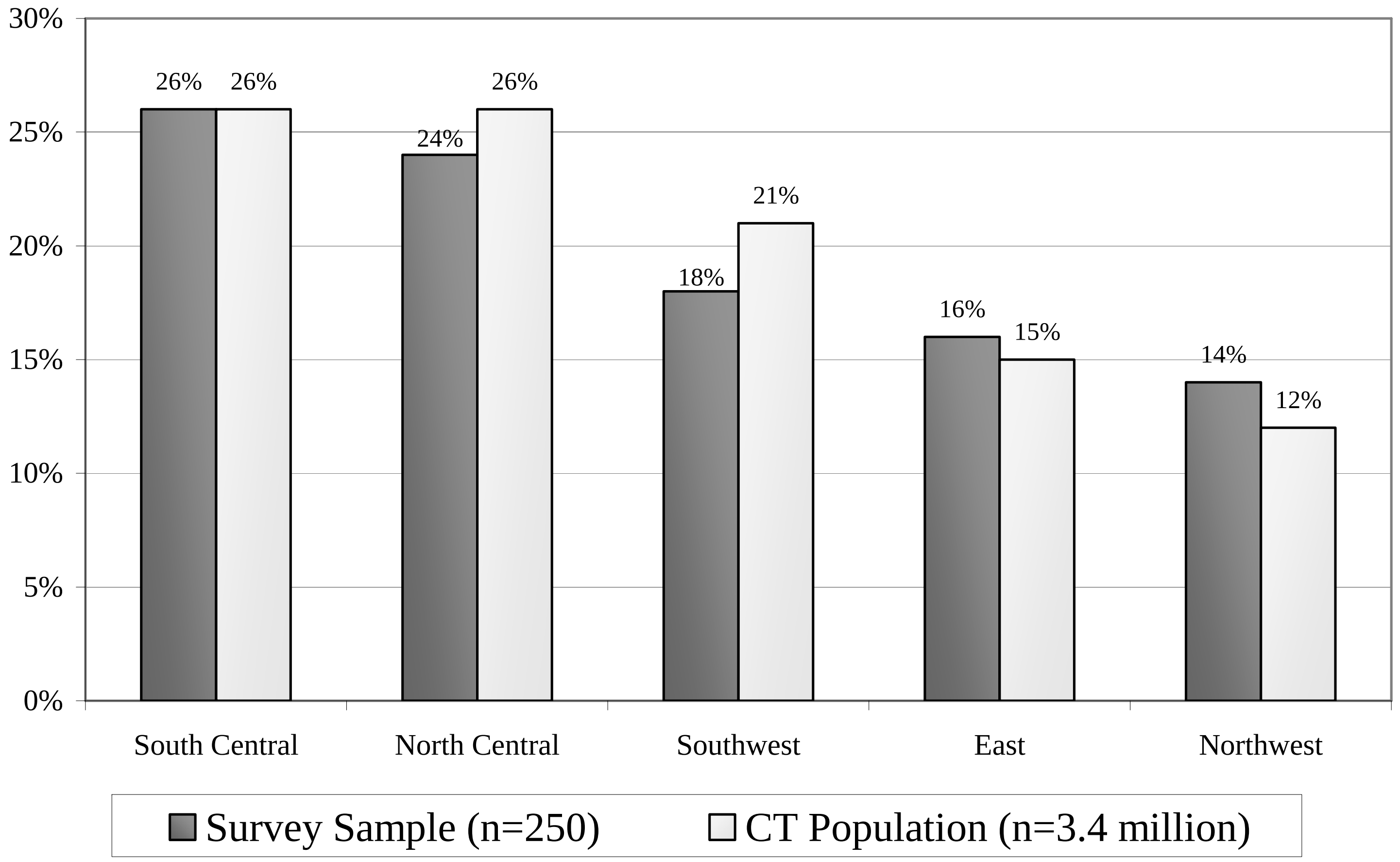
We found that 77% (193) of the respondents were adults aged 18 or over, with the remaining 23% (57) children and adolescents aged 17 and under. Only two were infants and toddlers under the age of three. Nearly three-quarters (41) of the child respondents were in the 3-12 age range, with a much smaller number (14) being adolescents from ages 13 through 17. The largest proportion of respondents (83), making up one-third of the entire sample, were adults between 36 and 50. Next most prevalent (58, or 23% of the sample) were those in the 51-64 age range. There were 10 young men and women (4% of the sample) in the 18-21 range, 34 (14% of the sample) between 22 and 35, and 8 respondents (3% of sample) above 65.

WHERE RESPONDENTS RESIDED

The respondents were widely distributed across Connecticut, reporting residence in 90 of Connecticut's 169 municipalities. The city of Bridgeport had the most respondents (11). There were 16 other cities or towns with 5 respondents or more. There were 41 cities or towns with just a single respondent.

Considering the self-selecting nature of our sample, the distribution of the respondents by region ran remarkably parallel to what we would have obtained in a random sample. Figure 1 displays the distribution of the sample compared to the state population as a whole.

Figure 1: Distribution Across Regions



The two most populous regions, South Central and North Central, each contain roughly 26% of Connecticut's residents and they gave us the largest number of respondents: 26% of our sample lived in the South Central region and 24% of the sample came from North Central. The Northwest is the least populous region (12% of Connecticut's total population) and we drew our lowest number of respondents, approximately 14% of our sample, from that region. The number of respondents from the two remaining regions also yielded survey respondents in the same order as their share of the state population. Southwestern Connecticut contains 21% of the population and was slightly under-represented in providing 18% of our sample. The Eastern region contains 15% of the population and yielded 16% of our sample.

Children were distributed somewhat differently on a regional basis from adults. In the Northwest, Southwest, and East, between 25% to 27% of respondents were under 18. In the other two regions, a somewhat lower proportion of respondents (18% in North Central and 21% in South Central) were under 18. Thus the state's two most populous regions had a stronger adult response to the survey while the other three regions drew a stronger response from children (or more precisely, from the parents who responded on their children's behalf).

We also looked at the respondents by whether they lived in cities of 100,000 or more; smaller cities and larger towns with populations above 15,000 but below 100,000; or smaller towns and cities under 15,000 population. Figure 2 displays the proportions of all Connecticut residents by the size of community in which they live, and Figure 3 displays the distribution of the adult survey respondents over age 21.

Figure 2: Connecticut's Population Distribution by Community Size (n=3.4 million)

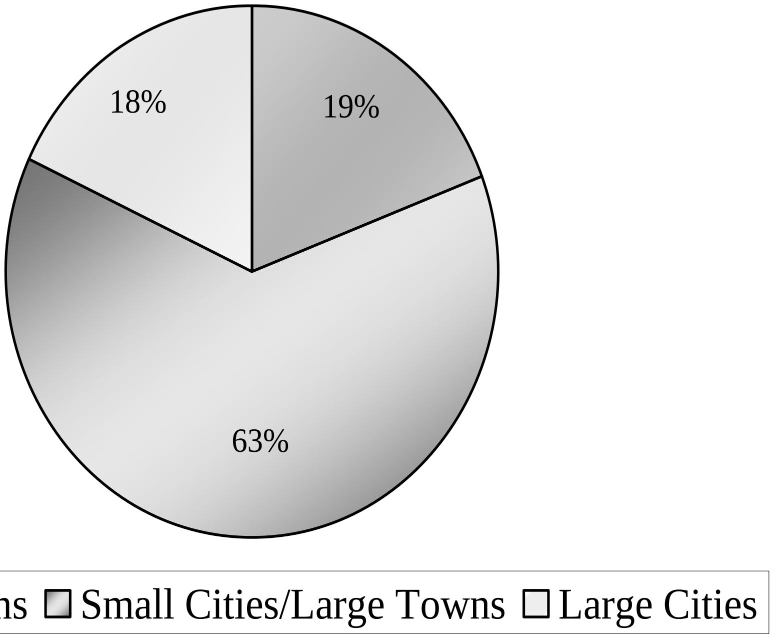
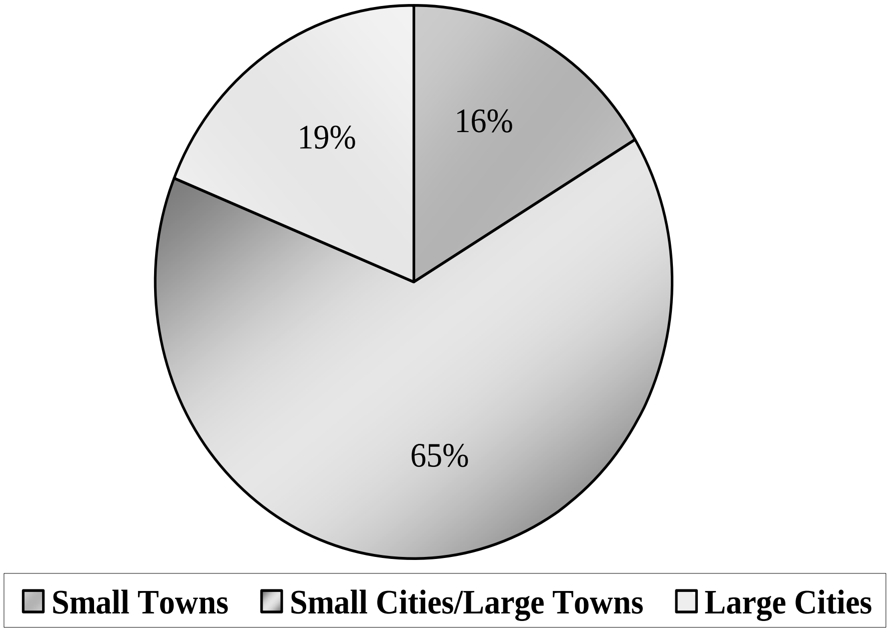


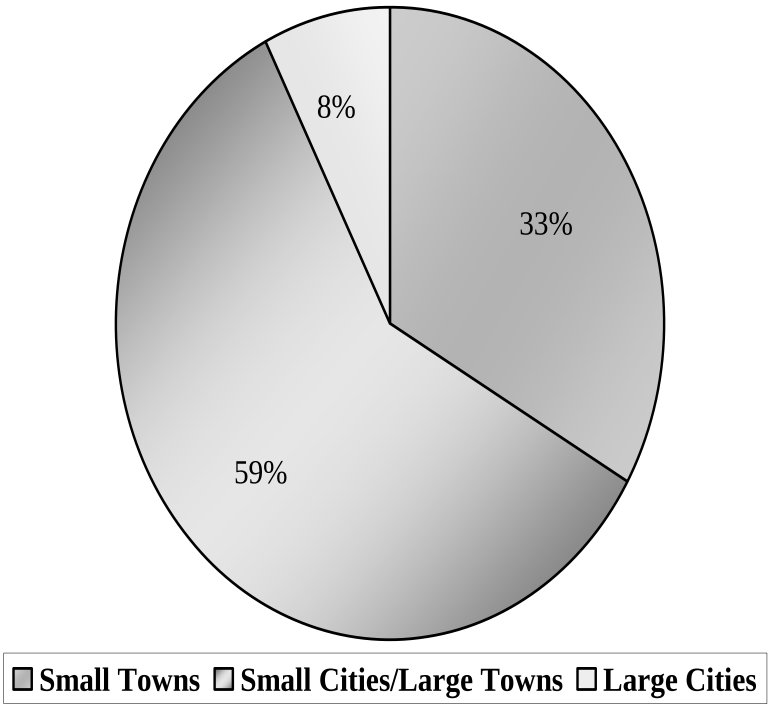
Figure 3: Size of Community in which Respondents 21 and Older Reside (n=184)



As illustrated in Figure 2, the larger towns and smaller cities contain roughly 63% of the state's population, with 18% in the large urban centers, and 19% in the smallest cities and towns. Figure 3 shows that our adult sample above age 21 tracked to an extraordinary degree the proportions we would have sought if we had constructed a random sample, with 65% living in the mid-sized communities, and fewer than one in five living in either the large cities (19%) or the smallest communities (16%).

Figure 4 displays the child and youth sample up through 21. This portion of our sample did not track the state population trends, as we drew very few respondents from the large urban centers (just 7% of those under 18, and 10% of the 18 through 21 year olds) and a sizable over-representation from the smallest cities and towns—one-third of the sub-sample.

Figure 4: Size of Community in which Respondents 21 and Under Reside (n=66)



TYPES OF DISABILITIES AND SUPPORT NEEDS

We asked respondents to state their type of disability. Table 1 displays the type of disability reported by our respondents, divided into age categories. One of five respondents mentioned additional disabilities, but 80% reported only one type. The table references only the first disability the respondent mentioned. The table also consolidates some disability labels used by the respondents into larger categories. For instance, we put those mentioning "genetic disorders," Prader Willi Syndrome, "multiple disabilities," and "system disease" into the other category, since they did not specify the kinds of functional impairments caused by these conditions. We combined speech delay with developmental delays to create a single category of "delayed speech or development."

The most frequently reported primary disability type across all age groups was physical. Physical disabilities were also the ones most frequently named as a second disability; more than one-third of the sample (87 respondents or 35%) listed physical disabilities either first or second. The second most frequent disability type reported was psychiatric: 25.2% reported this as first and another 1.6% mentioned it second. Nearly 10% (24) of respondents reported that they had visual impairment or were blind; exactly the same number (24) reported their primary disability as autism. The remaining disability types were diverse, and only learning disabilities accounted for as much as 5% of the total. There were very few respondents to the survey with cognitive (intellectual) disabilities: just 2.8% of the sample.

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Table 1: Respondents by Disability Type and Age Group (N=250)

NUMBER AND PERCENTAGE OF RESPONDENTS WITHIN EACH AGE GROUP REPORTING A GIVEN PRIMARY DISABILITY

Age Groups	**0-12**		**13-17**		**18-21**		**22-35**		**36-64**		**65 +**		**Total**	
Primary Disability Type														
Physical	9	20.9%	3	21.4%	2	20%	6	17.6%	42	29.8%	5	62.5%	67	26.8%
Psychiatric	1	2.3%	2	14.3%	1	10%	8	23.5%	51	36.2%	0	-	63	25.2%
Blind/Visual Impairment	3	7%	0	-	1	10%	3	8.8%	15	10.6%	2	25%	24	9.6%
Autism	16	37.2%	1	7.1%	1	10%	4	11.8%	2	1.4%	0	-	24	9.6%
Learning Disability	2	4.7%	4	28.6%	0	-	5	14.7%	2	1.4%	0	-	13	5.2%
Neurological	1	2.3%	1	7.1%	1	10%	1	2.9%	7	5%	0	-	11	4.4%
Traumatic Brain Injury	0	-	0	-	0	-	2	5.9%	8	5.7%	0	-	10	4%
Hearing Impairment	1	2.3%	1	7.1%	1	10%	2	5.9%	5	3.5%	0	-	10	4%
Cognitive	1	2.3%	0	-	1	10%	2	5.9%	3	2.1%	0	-	7	2.8%
Delayed Speech or Development	3	7%	1	7.1%	0	-	1	2.9%	0	-	0	-	5	2%
Other Disabilities	6	14%	1	7.1%	2	20%	0	-	6	4.3%	1	12.5%	16	6.4%
Total	43		14		10		34		141		8		250	

Looking only at the respondents aged 18 and over, psychiatric disabilities were the most frequently reported as the primary disability (31%) and physical disabilities were the second most frequently reported (28%). These were also the largest two categories found in the Harris survey sample,[1] but with the order reversed: 46% of respondents reported that someone in their household had a physical disability "limiting the use of legs, arms, or hands," while 28% stated that someone in their household aged 18 or over had "any emotional or mental disability or condition." Among the age group (36 through 50 years) that accounted for the largest portion of our survey sample (nearly one-third of all respondents), psychiatric disabilities were over-represented. Over 43% of the respondents in this age range identified a psychiatric disability.

Looking only at the child respondents under 18, autism was the most frequent disability type, accounting for 17 respondents, or 30% of the child sample. Physical disabilities were the second most likely to be mentioned, named first for 21% (12) of the child respondents. Learning disabilities accounted for 10.5% (6 respondents), and all others were well below 10%. Just one child respondent under 18 was identified as having cognitive (intellectual) disabilities. (Other children with cognitive impairments may have been reported as having delays in speech or development or fell into the column we labeled as other disabilities.)

Figure 5 compares the children ages 3 through 21 in our sample to the percentages enrolled in special education as reported by the Connecticut State Department of Education.

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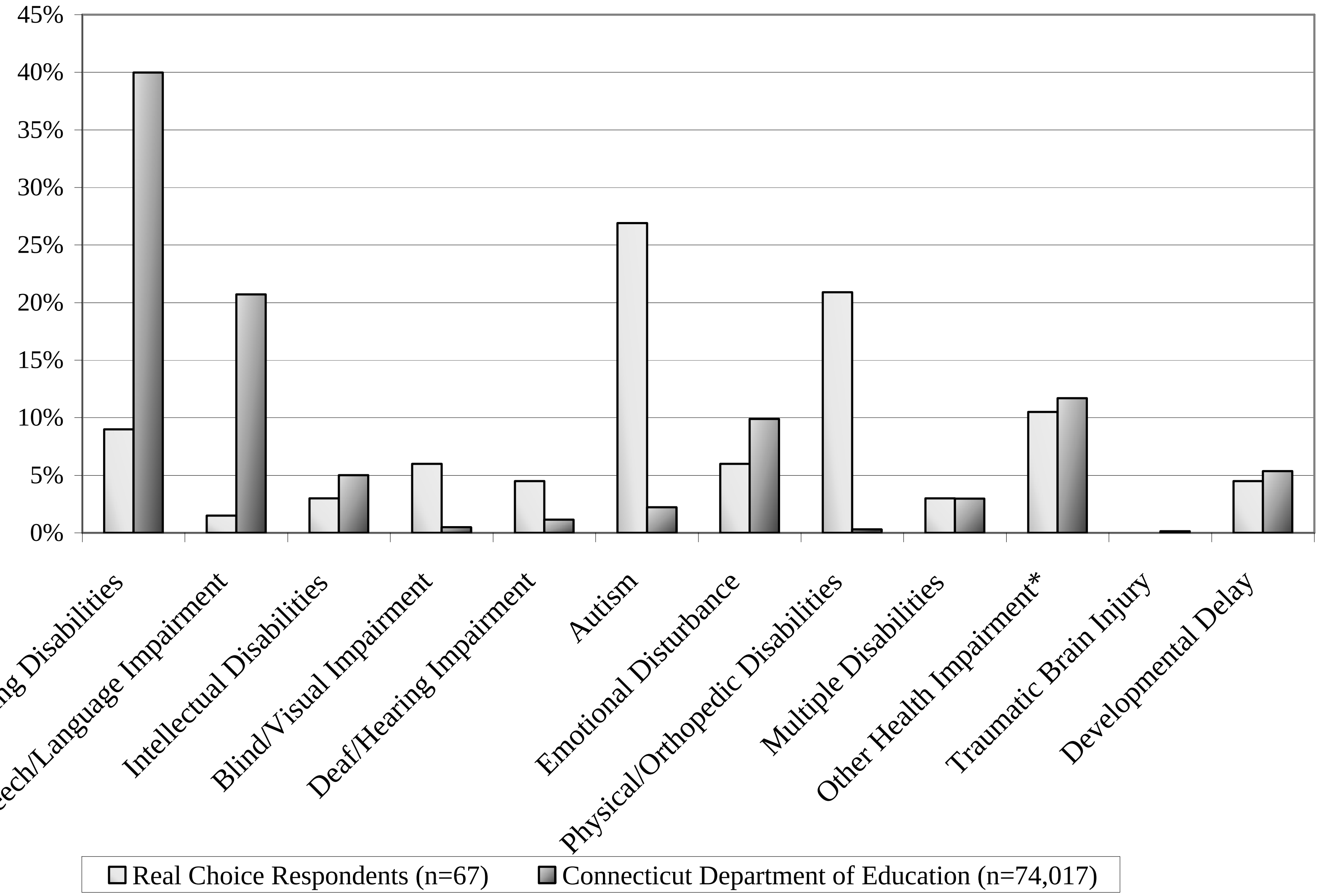
[1] Harris Interactive (2004) Gaps Survey

Figure 5: Children Ages 3-21 with Disabilities by Disability Type



*Some of the categories of our child-respondents do not match the IDEA disabilities.

As Figure 3 shows, our pool of child and youth respondents included large proportions who had autism and physical disabilities, but each of these makes up a tiny fraction of the population of children served in Connecticut's special education system.[2] We also drew responses from youngsters with vision and hearing impairment disproportionate to their percentage of the special education population. Conversely, over 60% of the state's special education students are classified as having either learning disabilities or speech/language impairment, but these categories made up much smaller proportions of our sample. The categories of learning disabilities and speech/language impairment (which are the largest all across the country and not just in Connecticut) include many children whose disabilities are regarded as "mild" and "moderate." The dramatic contrasts displayed so vividly in Figure 5 suggest that children and youth with more significant disabilities were far more likely than others to respond to our survey.

When we examined our respondents by the amount of help individuals said they needed, this supposition was confirmed. We asked respondents to indicate how much help they needed for daily activities by choosing "a lot," "some," or "none." Among our child respondent sample, there were 65% needing a lot of help, 35% needing some help, and 0% who did not need help. Thus we confirmed that the children (i.e., the parents or guardians) most likely to respond to our outreach efforts were those with the most challenging disabilities. Among respondents with the two most frequently reported conditions among children—autism and physical disabilities—the vast majority reported needing a lot of help with daily activities: 71% for those with autism and 92% for those with physical disabilities.

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[2] Children who have physical disabilities are not always eligible for special education services. If their support needs are in the realms of mobility or health care, for instance, but they are able to participate in the regular classroom curriculum, then they may have "504 plans" under the aegis of Section 504 of the Rehabilitation Act of 1973 but not Individualized Educational Programs required under the aegis of IDEA.

Among adults from 18 and up, we found that 24% of our sample needed no help, 59% needed some help, and 16% needed a lot of help with daily tasks. The Harris/N.O.D. survey[3] asked respondents, "Do you ever use personal assistants or get help from someone with basic needs such as getting dressed, preparing meals, or bathing?" They received a yes response from 19% of their respondents with disabilities, which is similar to our 16% of adults who needed a lot of help. In the same survey, respondents selected from a menu describing their disabilities or health problems as "slight," "moderate," "somewhat severe," or "very severe." The respondents included 60% who selected "moderate" (27%) or "somewhat severe," (33%) which totals 60% and corresponds closely to the 59% in our adult sample (18 and over) who needed some help. The percentage choosing "slight" (18%) in their sample was lower than the percentage of our adult respondents who did not need help (24%). Conversely, our adult sample included a slightly lower proportion of respondents needing a lot of help (16%) than those in the Harris/N.O.D. who described their condition as very severe (20%).

The modal response for the entire respondent pool was "some," with 54% providing that answer. There were nearly 19% who responded "none" and 27% who needed "a lot" of help with daily activities. However, as we have seen, these life span data are not very meaningful as they mask the enormous differences in the response of our child sample compared to our adult sample.

ETHNIC AND GENDER COMPOSITION

There were slightly more males than females among the respondents (54% to 46%). Approximately 86% of the respondents identified themselves as White/Caucasian, with 8% identifying as Black/African-American, and the remainder racially mixed or other ethnic groups.

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[3] Harris Interactive (2004) Gaps Survey.

Just a single (1) respondent self-identified as Asian. Connecticut's population statistics from the 2000 Census indicate that White/Caucasians make up 82% of the population, Blacks or African-Americans 9%, and Asians nearly 2.5%. Our survey came close to reflecting these statewide proportions among Whites and Blacks but under-represented Asians. It is likely, but not certain, that our sample also under-represented individuals of Hispanic or Latino ethnicity.[4]

VERY FEW "CLUSTERED" RESPONDENTS

We made no attempt to secure a random sample, nor did we develop a purposively stratified sample of consumers, but simply sent out information about the survey and invited consumers with disabilities, through various channels, to "come one, come all." The respondents were self-selected within the universe of all those who learned about the survey and were eligible. Our sample composition could have been greatly skewed in comparison to a random sample if numerous members of a network (e.g., parents of children with similar disabilities from the same city or adults with a common condition) decided as a group to complete the survey.

We tested for this phenomenon by examining the characteristics of respondents from cities or towns in which two or more respondents resided. Of 49 cities or towns in which this was the case, we took a close look at 15 communities: 3 (Bridgeport, Groton, and New Haven) which have been designated as Real Choice "model communities,"[5] plus 12 others (a 25% sample) chosen randomly from the remaining 46. The populations of those randomly selected

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[4] Current federal census data (and the Harris survey) ask respondents if they are "of Hispanic origin, such as Mexican American, Latin American, Puerto Rican, or Cuban." (In the most recent Census, 9.5% of Connecticut residents said yes.) In a separate question, respondents to the Census are asked to select their racial/ethnic group--a list that does not include Latino or Hispanic.) Our survey muddied this point because we omitted the separate question about Hispanic origin and added Hispanic/Latino as a choice among the ethnic/racial groups. We had three respondents who identified themselves as Hispanic/Latino, but we don't know if others were hidden beneath the racial categories of White or Black.

[5] Under the Real Choice Systems Change grant one objective is to build capacity through technical and financial assistance in three specific communities which are already demonstrating good progress in the area of community inclusion.

ranged from Sprague and Niantic (just under and just over 3000 residents) to Norwalk (nearly 83,000).

Looking at the age levels and the nature of their primary disability, we could see that only in a few instances did the survey respondents seem to cluster around specific disabilities from any one community. In one city we found four respondents, all in the 36-50 or 51-65 age range, who named their primary disabilities as psychiatric. In two of the communities there were two children with autism (and in one of them, there was also an adult respondent with autism). Together with the statewide geographic distribution we have already described, the fact that we found few of such clusters among the portion of the sample we examined in detail reassures us that our self-selected sample was suitably diverse and not generally skewed by connections to specific interest groups.

SUMMARY OF SAMPLE COMPOSITION

In summary, our sample was broadly dispersed throughout Connecticut, with the proportions living in the five regions parallel to the state population as a whole. Adult respondents lived in smaller towns, larger towns, and major urban areas roughly in proportion to state residents as a whole. However, child respondents were over-representative of the smallest towns and very few came from the urban centers. The ethnic composition of the sample reflected that of the state as a whole for Whites and Blacks but not for Asians or Latinos, and the range of ages was diverse.

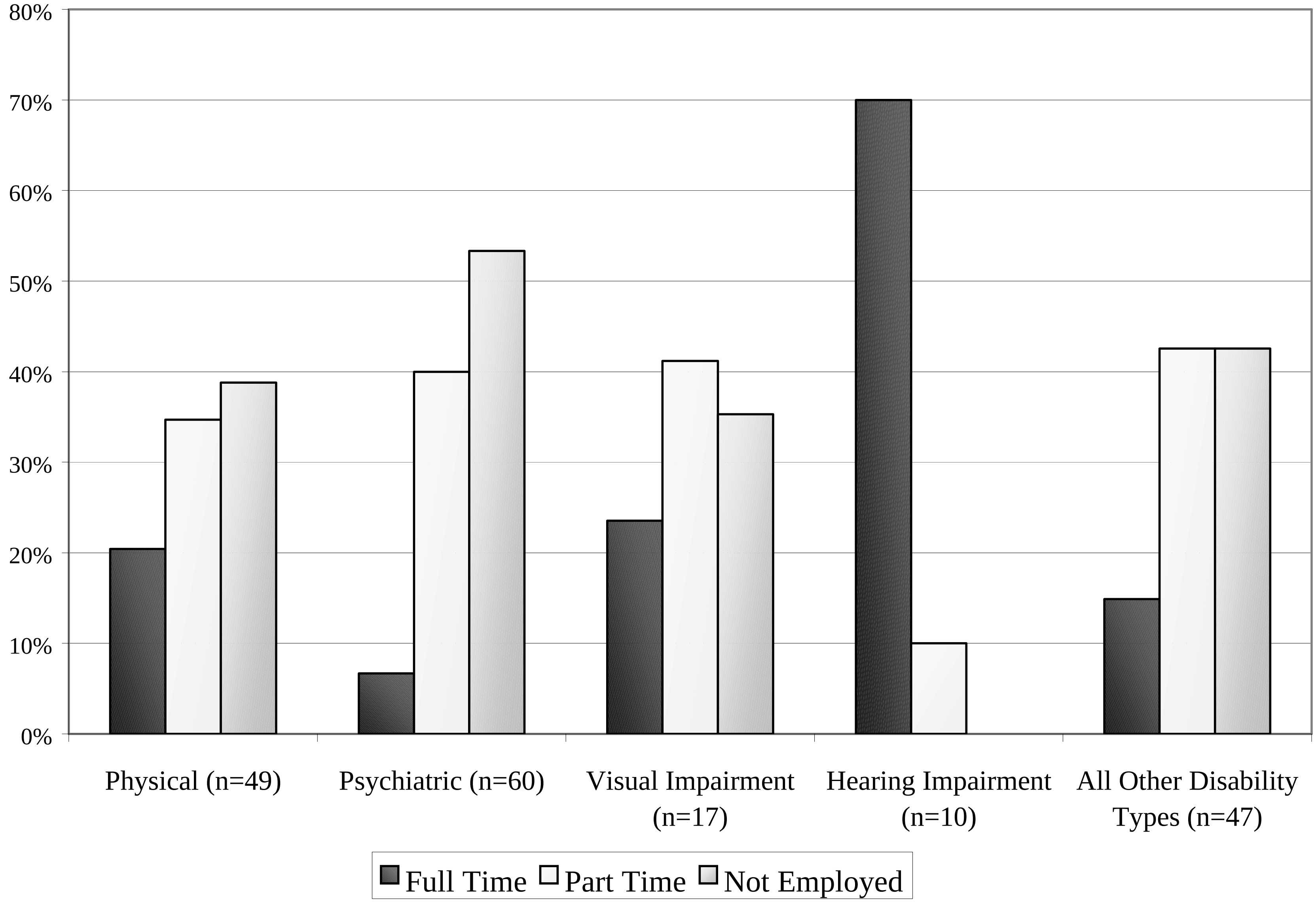
The sample represented a diverse distribution of disabilities, with the exception that psychiatric conditions were over-represented among middle-aged adults, cognitive (intellectual) disabilities were under-represented across the life span, and autism and physical disabilities were over-represented among the child sample. The proportions of adult respondents in our sample who reported needing <u>a lot of help</u> compared to those needing <u>some help</u> and <u>no help</u> resembled the proportions in a national Harris sample. However, our child-sample was heavily weighted toward respondents who needed <u>a lot of help</u>. Finally, it appears that the vast majority of individuals responded to the survey independently, and not in concert with other members of consumer and family networks.

SURVEY FINDINGS

EMPLOYMENT

Figure 6 displays working-age respondents (ages 18 to 64) categorized by primary disability types and shows what percentage were either employed full-time, employed part-time, or not employed. We left out of this display five respondents (out of 183 individuals of working-age) who reported themselves as self-employed.

Figure 6: Frequency of Employment Within Disability Types



*Three respondents (6%) with physical disabilities and two respondents (20%) with visual impairments reported being self-employed.

We found that across all adult age groups from 18 through 64, 58% of our sample was engaged in some kind of gainful employment, either part-time, full-time, or in self-employment. However, the full-time employment rate was just 17.5%.[6] Bureau of Labor Statistics 2002 figures indicate that the employment rate in 2000 in CT for persons aged 16 and over in the population in general was 62.8%. A data sample showed that 80.19% were employed full time (35 hours or more).[7]

As the graph makes clear, the highest proportion of full-time employment examined by type of disability was among those with deafness or hearing impairment (87.5%). Among smaller numbers of working-aged respondents with cognitive disabilities or neurological impairments, one-third reported full-time employment. (These are merged along with others into "other disabilities" on the graph.) All other disability types had rates of full-time employment lower than 25%. Among our largest group of adults, those with psychiatric disabilities, the full-time employment rate was only 6.7%. Among the second most prevalent group, those with physical disabilities, the rate was slightly over 20%. Among the third most prevalent group, those who were blind or visually impaired, the rate was 21%.

Combining full-time, part-time, and self-employment work, adults with visual impairment or blindness reached a 68% employment rate, compared to 61% for individuals with physical disabilities and 47% for those with psychiatric disabilities. None of our seven working-age adults with learning disabilities reported full-time employment, but six of them had part-time

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[6] Some of those unemployed (and part-time employed) in the 18-21 year age group were still in high school. If we looked only at the adults from 22 through 64, the full-time employment rate would be 18.5% and the total employment rate (either part-time or full-time) would be 60%.

[7] Bureau of Labor Statistics: Geographic Profile of Employment and Unemployment, 2002 Section II: Estimates for States, table 13 http://www.bls.gov/opub/gp/pdf/gp02_13.pdf

jobs, for an 86% rate. As displayed in the graph, the employment rate for survey respondents with deafness or hearing impairment was 100%.

Examining employment by age segments, we found that among those 22 through 35, 76% of our respondents reported that they were employed--about three-fourths part-time and one-fourth full-time. Among respondents aged 36 to 64 (the largest segment of our sample) the overall rate was 57%. One-third of the employed respondents, ages 36-50, worked full-time, and just one-fourth of those 51-64 were employed full-time.

How Amount of Help Needed and Age Influenced Rates of Employment

Employment among our younger respondents was not related to how much help they needed with daily tasks; however, among older respondents, there was a reduced employment among those needing a lot of help. Fully 86% of respondents ages 22 to 35 who needed a lot of help were employed, while roughly 40% of respondents needing a lot of help were employed at ages 36 to 50 and 51 to 64.

Comparison to National Sample

A comparison to national data from the Harris/National Organization on Disability surveys is possible, because both surveys offered similar questions about employment. Harris surveyed adults without disabilities as well, so it is possible to compare our data both to their nationally drawn random sample of adults over 18 with disabilities and to their nationally drawn random sample of persons without disabilities.

The Harris/N.O.D. survey found much lower employment among their respondents with disabilities. Only 32% of their national sample of working-age (18-64) respondents with disabilities was employed full- or part-time, compared to 81% of working-age people without disabilities whom they sampled.[8]

Figures obtained from the Connecticut Department of Labor indicate that in November 2004, the unemployment rate for Connecticut was 4.7%, which was better than the national rate of 5.4%. However, the difference between these two figures is far smaller than the discrepancy we found between the employment rate for our respondents and those profiled in the national Harris sample.

As to the proportion of those without jobs who were seeking employment, among our respondents this came to 43.5%. The Harris sample found two-thirds of their non-employed respondents under 65 years of age wishing to be working.[9] On closer inspection of our data, we found that responses varied dramatically by the ages of respondents. While 87.5% of those not currently employed at ages 22-35 were looking for work (higher than the percentage in the Harris sample), a substantially lower 42% of respondents not employed at ages 36-50 were looking for work. Among respondents, ages 51-64, who were not currently employed, the proportion seeking employment dropped to just one-third (32%).

TRANSPORTATION

Among Harris/N.O.D. respondents,[10] 30% of persons with disabilities reported lack of transportation to be an important problem (compared to 10% of persons without disabilities). In our survey, we did not ask if respondents considered transportation (or the lack of it) to be a problem. Our survey, however, posed a series of questions regarding the types of transportation respondents used.

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[8] Harris Interactive (2000) Gaps Survey. We used the earlier Gaps survey for this comparison because it disaggregated the working-aged data from older respondents.

[9] Harris Interactive (2000) Gaps Survey.

[10] Harris Interactive (2000). Gaps Survey.

We found that of adults 18 and over, 52% reported that they drove. This may be one of the reasons why such a strong percentage of our adult sample was gainfully employed and also (as we shall see below) reported a robust level of involvement in community activities. Of those who did not drive, more than three out of five (62%) reported that they used buses and nearly three of five (59%) used para-transit.

In the larger towns/small cities and in the urban centers, the proportion who drove was about half (between 47% and 49%). But among respondents living in the smallest cities and towns, nearly two-thirds (64%) drove. The disabilities that had the largest percentage of drivers among our respondents were hearing impairment (87.5% of 8 adult respondents), system disease (83% of 6 respondents) and psychiatric (72% of 59 respondents). Another large group of drivers among our respondents were those with physical disabilities (58%). By contrast, those with autism (0% of 6), visual impairment (5% of 20), and neurological conditions (22% of 9) were much less likely to drive.

Not surprisingly, the use of buses was associated mostly with those living in the medium-sized to largest towns and cities. Only one-fifth (18%) of residents of small towns used the bus, but this rose above one-fourth (27%) in the large towns/small cities and to well over half (58%) in the five large cities. Use of para-transit was nearly identical to use of buses for the large town/small city residents (26%), while it was used by only 9% of small town residents and 31% of large city residents—far below use of buses. The taxi was used by low percentages of small town residents (12%) and large town/small city residents (18%) but by 31% of large city residents.

Looking only at those adult respondents who reported they did not drive, almost two out of three (62%) reported they used the bus, nearly three in five (59%) reported using para-transit, and 45% reported using a taxi at times. Examining the disability categories in which respondents mostly did not drive, we found that 50% of adults with autism reported using the bus, 53% of adults with visual impairment used the bus, and 71% of those with neurological conditions used the bus. All the respondents who reported not driving also answered <u>no</u> to each of the other transportation options. In other words, every respondent used at least one form of transportation. The data do not tell us, however, the degree to which these transportation options met their needs.

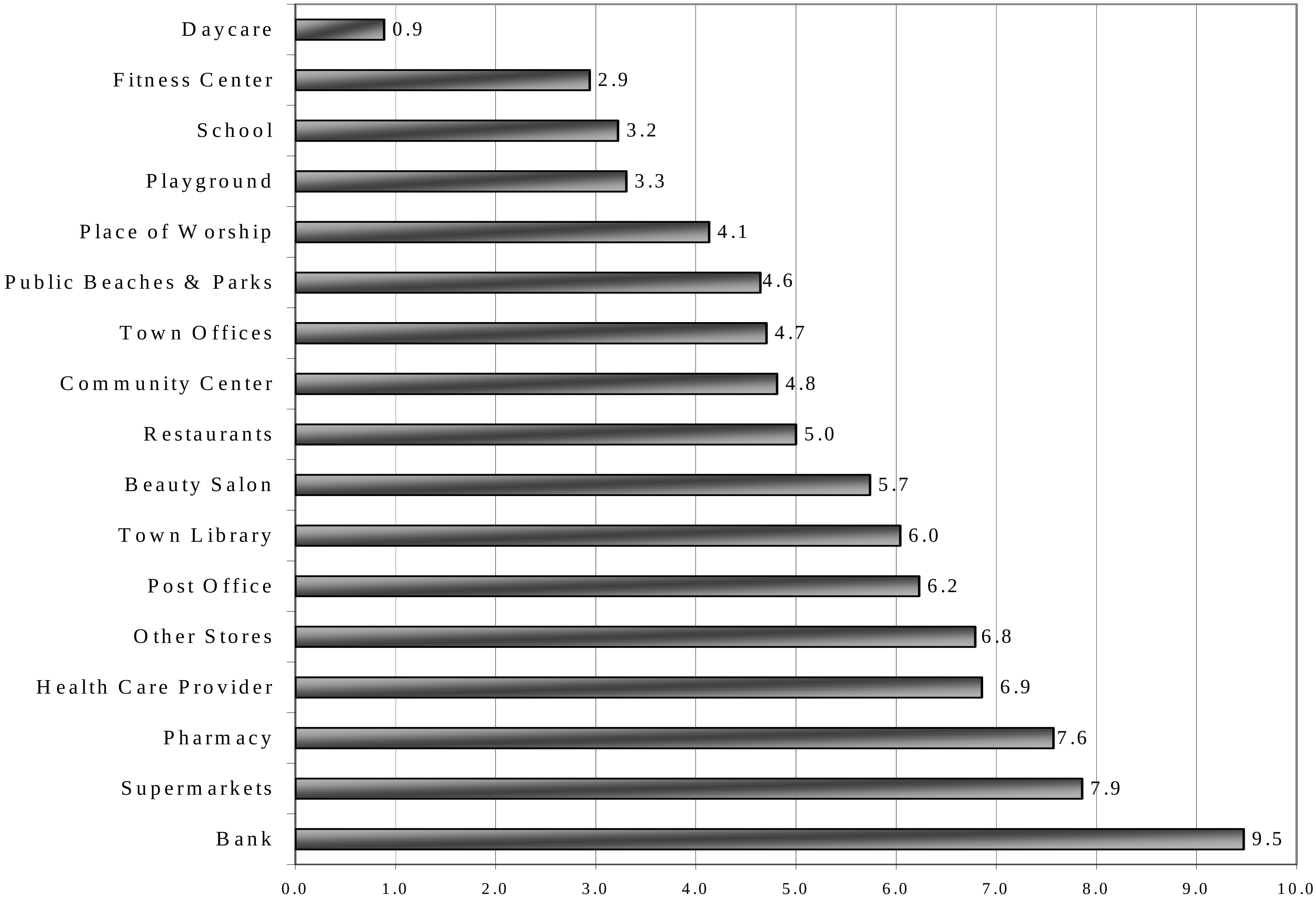
ACCESSIBILITY IN SELECTED LOCAL SETTINGS

We asked respondents to inform us about their perceptions of accessibility in the cities or towns in which they lived. Our survey defined accessibility as having two facets: (1) <u>able to enter</u> and (2) <u>able to use the services</u>. We asked respondents to rate each of 17 public and private entities such as stores, public parks, and barbershops/beauty parlors as “fully accessible,” “partially accessible,” or “not accessible.” They also had the option of declining to answer or of indicating that they did not know.

As “partial” accessibility is an inconclusive judgment that could be viewed either positively or negatively, depending on the circumstances, we found it most useful to focus our analysis on responses judging a given entity as either <u>fully</u> accessible or <u>not</u> accessible. We developed an <u>accessibility index</u> based on the ratio of respondents rating a given venue as <u>fully accessible</u> to those rating it <u>not accessible</u>. Thus, if an equal number of respondents rated it <u>fully</u> and <u>not</u> accessible, its accessibility index would be <u>1.0</u>. If 5 times more rated it <u>fully</u> than <u>not</u> accessible, the index would be <u>5.0</u>.

Figure 7 shows the accessibility index computed for the 17 venues we asked about in our survey.

Figure 7: Accessibility Index



The Accessibility Index was calculated by dividing the number of respondents rating a location fully accessible by the number of respondents rating that location inaccessible. The higher the index, the more accessible the location.

There were four entities that nearly two-thirds of our respondents rated as fully accessible. These were the supermarket (66.5%), the post office (65%), the bank (65%), and the pharmacy (64%). The percentage that rated the bank as not accessible (7%) was smaller than any of the others; therefore, it received the highest accessibility index (9.5). The somewhat larger percentage of respondents rating the post office as not accessible (10.5%) reduced its index to 6.2. Health care was rated fully accessible by fewer (58%) than the other venues mentioned, but as very few respondents (8%) found it to be not accessible; its index of 6.9 surpassed that of the post office.

The town library (6.0) had nearly the same index as the post office while other public entities—community centers (4.8), town offices (4.7), public beaches and parks (4.6), playgrounds (3.3), and schools (3.2) were viewed on average as modestly less accessible. Among private entities (besides the three mentioned earlier), beauty salons/barbershops (5.7) drew better ratings than restaurants (5.0), which in turn did much better than fitness centers (2.9).

Houses of worship did not fare impressively, with 50% stating their chosen religious venues were fully accessible but 12% rating their preferred houses of worship as not accessible, for an index of 4.1. Daycare (meaning in the minds of the respondents, we presume, either home-based or center-based childcare) was the only entity on the list of 17 that more respondents rated not accessible than fully accessible and therefore received an accessibility index below 1.0.

Child-Oriented Locales

For three settings (school, playground, and daycare) it may be more meaningful to look only at the ratings of respondents under 18. We found 68% of this sub-sample rating the school fully accessible, 51% rating the playground fully accessible, and just 22% rating the daycare fully accessible. Conversely, 10.5% rated the school not accessible, 16% rated the playground not accessible, and 28% rated the daycare not accessible. These proportions yield the following accessibility indices: 6.5 for the school, 3.2 for the playground, and 0.8 for the childcare provider. In other words, there was little difference between the child sample and the entire sample in ratings of the playground and the daycare. But the respondents under 18 gave much better ratings to the accessibility of the school than did the wider group of respondents, indicating that those currently involved with the schools are more satisfied with accessibility than those whose school experience was completed some years earlier.

Respondents with Physical Disabilities

Because accessibility is a more salient issue for individuals with physical disabilities, we examined the accessibility ratings of all respondents ages 18 and over who identified a physical disability as either their first or second disability. The supermarket and the bank still rated very well among this sub-sample (7.0 and 6.8 accessibility indices, respectively). However, the post office (3.4) did not rate as favorably as among survey respondents as a whole. Nearly 17% (one in six) found their post offices to be not accessible. Town offices (2.9) and public beaches and parks (1.6) also did not rate well among this sub-sample, with 17% and 20% selecting not accessible for these two locales, respectively.

We also examined the ratings provided by a subset of respondents who had physical disabilities and indicated they needed a lot of help for daily tasks. We would predict this to be the group that found the greatest barriers to accessibility. Among adults in this category, the not accessible ratings rose to 33% for town offices and 31% for health care providers, while public parks (8%) and places of worship (9%) drew the fewest ratings of not accessible. The post office (60%) and the place of worship (63%) drew ratings of fully accessible from the greatest proportion of these respondents. Respondents 21 and under in this subgroup also gave favorable ratings to the post office (71% said fully accessible) but their response to the place of worship was quite polarized: 64% rated it fully accessible and a sizable 27% not accessible. A preponderance of child respondents with physical needs found several other venues in their respective communities fully accessible: the town library (77%), health care provider (69%),[11] the school (67%), and the town office (64%).[12]

Not surprisingly, the response of this subgroup of child respondents to the three child-oriented locales was more negative than for child respondents generally. There were 20% rating the school not accessible, 33% rating the playground not accessible, and 75% rating the daycare not accessible.

COMMUNITY PARTICIPATION

Another section of our survey examined participation in a broad range of arenas such as personal friendships, community events, social, cultural, volunteer, and recreational activities in the community. This portion of the survey was adopted without substantial revision from the Harris/N.O.D. survey,[13] permitting us to draw comparisons to their national sample of persons with disabilities and typical peers.[14] Table 3 compares selected data from the Harris survey and the Real Choice survey with reference to respondents aged 18 and over.

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[11] While 31% of adults with a lot of physical help needs found health care providers to be not accessible, this was the case for just 15% of the child respondents.

[12] While one-third of the adults in this sub-sample found town offices inaccessible, this was the case for only 9% of the children.

[13] Harris Interactive (2000). Community Participation Survey.

[14] The Harris wording of some of the questions in this section seemed potentially confusing. They asked about attendance at "recreational activities such as sporting events or movies." The word recreational would seem to connote participation in athletics or exercise, but the phrase sporting events, especially when paired with movies, is more suggestive of spectator sports. They asked separately about community service organizations, and this seemed to connote recreation, given their use of the YMCA as illustrative. They asked about ballet, opera, and theatre in a question related to cultural organizations, but included movies in the question about recreation. Nevertheless, in order to make our data comparable to the Harris findings, we adopted these questions for our survey without any revisions in the wording.

Table 3: Community Participation for Respondents Ages 18 and Older

	REAL CHOICE (N=193)	HARRIS	
		Persons with Disabilities	**Persons without Disabilities**
Attended sporting events or movies at least once a month	37.3%	38%	52%
Occasionally attended special events in community	69.4%	79%	83%
Visited cultural events or organizations in community at least once a month	36.8%	31%	39%
Socialized with close friends, relatives, or neighbors at least once a week	67.9%	67%	64%
Went to outdoor community spaces at least twice a month	33%	29%	40%
Went to a local service organization at least once a month	16.1%	12%	12%
Attended events related to their hobbies at least once a month	31.1%	31%	35%
Went to a place of worship at least once a month	42%	36%	37%
Participated in volunteer work at least twice a month	32.7%	16%	21%
Participated in local politics at least once a month	6.7%	8%	9%

Spectator Sports, Special Community Events, and Cultural Destinations

Harris found that 52% of persons without disabilities and 38% of persons with disabilities attended sporting events or movies at least once a month. This was the case for 38% of our respondents as well. Harris found that 83% of persons without disabilities and 79% of persons with disabilities occasionally attended special events in their community such as fairs and parades. In our survey, we found 69% who did so. Harris found that 39% of persons without disabilities visited cultural events or organizations in their communities at least once a month, and that 31% of persons with disabilities did so. Among our respondents, the figure was 37%.

Social Life, Routine Community Activities, and Hobbies

Harris found that 64% of persons without disabilities socialized with close friends, relatives, or neighbors at least once a week. Harris found this to be true for a slightly higher percentage (67%) of persons with disabilities. Among our sample, the figure was virtually the same, 68%.

Harris found that 40% of persons without disabilities and 29% of persons with disabilities went to outdoor community spaces such as a park or a beach at least twice a month. Among our respondents, the figure was 33%.

Harris found that 12% of persons without disabilities and a comparable 12% of persons with disabilities went to a local service organization such as a YMCA, the Girl Scouts, or a 4-H Club at least once a month. Among our respondents, it was 16%.

Harris found that 35% of persons without disabilities attended events related to their hobbies at least once a month, and that 31% of persons with disabilities did so. Among our respondents, an equivalent 31% reported involving themselves in such activities at least once a month.

Religious Worship, Volunteer Work and Politics

Harris found that 37% of persons without disabilities reported going to church, synagogue, or any place of worship at least once a month. Harris found this to be true for 36% of persons with disabilities. Among our sample, the figure was 42%.

Harris found that 21% of persons without disabilities participated in volunteer work at least twice a month, compared to 16% of persons with disabilities. Among our respondents, the frequency was 33%.

Harris found that 9% of persons without disabilities participated in local politics at least once a month, compared to 8% of persons with disabilities. Among our respondents, fewer than 7% participated once a month in local politics.

Feelings About Communities and Involvement

In addition to questions about the frequency of specific arenas of community involvement, we posed eight questions relating to the feelings of respondent's vis-à-vis their communities. These questions, like the community participation questions, were adopted without revision from the Harris/N.O.D. survey,[15] but some were asked in a different sequence. We have displayed some of these responses in Figure 8.

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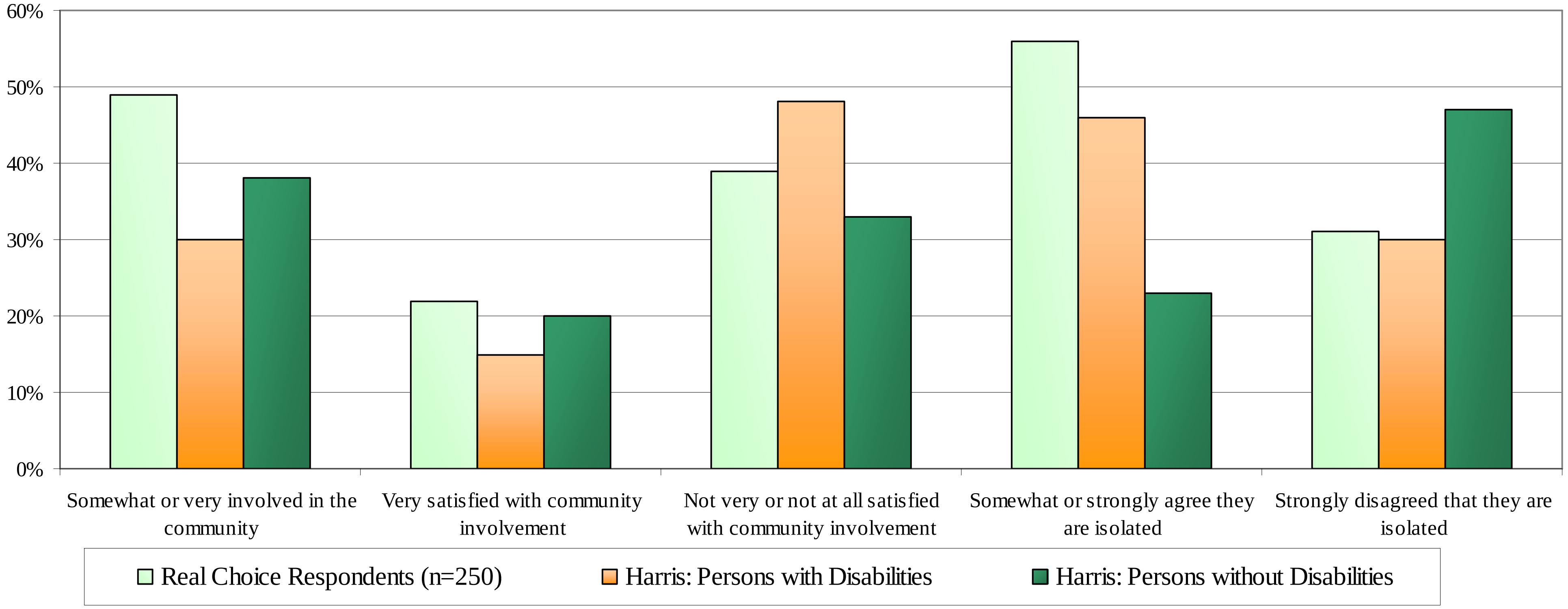
[15] Harris Interactive (2000). Community Participation Survey.

Figure 8: Feelings About Communities and Involvement



We asked, “How involved would you say that you are in your community?” Among the Harris sample, 38% of persons without disabilities were very or somewhat involved, and 30% of persons with disabilities were very or somewhat involved. Among our Connecticut respondents, nearly half (49%) were either very or somewhat involved—more than either of the Harris samples. Whereas 35% of the national sample of persons with disabilities stated they were not at all involved, that was the case only for half as many (16%) of our Connecticut sample.

We asked respondents, “Over the past year, how satisfied have you been with your experience with community involvement?” In the Harris sample, 20% of persons without disabilities and 15% of persons with disabilities reported that they were very satisfied. Among our respondents, nearly 22% were very satisfied. On the other end of the spectrum, Harris found that one-third (33%) of persons without disabilities and nearly half (48%) of persons with disabilities were either not very satisfied or not at all satisfied with their community involvement. Among our respondents, 39% fell into these two categories. The frequency with which respondents stated they were not at all satisfied in our sample (14%) was noteworthy but not nearly as great as in the national sample (23%).

Nearly half (49%) of persons with disabilities answering the Harris poll and over half (55%) of persons without disabilities somewhat or strongly agreed they were “valuable and contributing members” of their communities. Among our Connecticut sample, 63% either somewhat or strongly agreed with this statement. Slim majorities of persons with disabilities in both surveys somewhat or strongly agreed that they were “informed about the ways” they could volunteer or otherwise participate in their communities (53% of the Harris sample, 50% of our sample). A similar proportion (51%) of our sample somewhat or strongly agreed they were informed "about community groups or organizations" that could provide assistance; a smaller proportion of persons with disabilities in the national sample (41%) selected those responses.

The survey framed a few questions in the negative. Asked to agree or disagree with the statement, "I am not regularly invited to give my opinion on important issues," Harris found that about half of persons without disabilities agreed (54%) either somewhat or strongly, while half disagreed (46%) either somewhat or strongly. Among the national sample of persons with disabilities, more persons with disabilities agreed (65%) and fewer disagreed (35%) with the statement. Among our Connecticut respondents, we found the same percentage as among those with disabilities in the national poll (65%) agreeing either somewhat or strongly that they were not invited to give their opinions. An even larger percentage strongly agreed with the statement among our Connecticut sample (38%) than in the national sample of persons with disabilities (30%).

When asked to agree or disagree with the statement, "I am isolated from others," roughly the same proportion of persons with disabilities in our survey and the Harris poll of persons with disabilities strongly disagreed (31% and 30%, respectively). But 46% of the Harris respondents with disabilities and 56% of the Connecticut respondents agreed they were isolated, either somewhat or strongly. Among the Harris respondents without disabilities, just 23% somewhat or strongly agreed they were isolated and 47% strongly disagreed. Similar percentages agreed and disagreed that they were "left out of things" in their communities. Only 24% of the Connecticut respondents strongly disagreed with that statement and a similar 29% of the Harris respondents with disabilities strongly disagreed. Of those without disabilities, a similar percentage (32%) disagreed strongly with the statement. Fully 56% of the Connecticut respondents also indicated they were isolated, either somewhat or strongly. This is higher than the proportion (46%) that gave these responses among the Harris sample of persons with disabilities.

RESPONDENT RATINGS OF COMMUNITIES OVERALL

After answering all the other questions, we asked each respondent to rate her or his community on a scale of 1 to 5, in regard to "accessibility, participation, and how welcomed you feel." The lowest number (1) was the worst rating and the highest number (5) was the best. Of all respondents who answered this question, 30% chose to assign the number 3 to their city or town—a rating that should be viewed as neither good nor bad but rather the halfway point between worst and best. The ratings of 2 and 4 were selected by an almost equal proportion of respondents (24.7% and 23.1%). A larger proportion (13.8% compared to 8.5%) rated their community most favorably (5) versus the least favorably (1).

A Closer Look at a Sample of Communities

In hopes of gaining a richer perspective on the consumer ratings of the accessibility of specific locales plus their ratings of the community overall, we took a close look at a sub-sample of responses from 15 communities. These included Bridgeport, Groton and New Haven, which have been designated as Real Choice "model communities," and a 25% sample (12 communities) of the remaining 46 municipalities in which we had two or more respondents. As indicated earlier, the populations of the selected communities ranged from Sprague and Niantic (around 3000 residents each) to Norwalk (about 83,000). From the list of 17 locales which the survey asked respondents to rate, we purposively selected 7 for careful scrutiny. We chose three that were publicly operated by local government (public parks, town offices, and library). We chose one operated by the federal government (the post office). We chose three that lie in the private or private/nonprofit realm (beauty salon/barbershop, place of worship, and health care provider).

We looked at how each respondent rated each of these seven locales in each of the 15 selected towns or cities and compared them to the responses of the others from the same community. In doing so, it was important to recognize that some of the entities converged on a single venue (e.g., the town library or post office in a municipality with only one town library or post office). But most were divergent, meaning that individuals from the same community were not necessarily rating the same location. For instance, a respondent in a larger town or city coming to the phrase <u>town library</u> or <u>post office</u> might rate either the main library or postal station or a library branch or postal substation. To rate a <u>place of worship</u>, a respondent would consider the accessibility only of that house of worship that interested him or her. Rating a <u>health care provider</u>, a respondent would consider his or her own habits and preferences, as most communities offer several choices. (In cases where consumers patronized a health care provider in a town other than the one in which they resided, we surmise that some respondents left the answer blank, while others rated the setting as if it were located within their local community.)

We found that the responses from the sub-sample of cities and towns did not readily sort themselves into “accessible” and “inaccessible” locales or communities. There was wide variability within communities and the variability didn’t seem to be associated with any particular factor, such as type of disability. It was no surprise that individuals with physical disabilities would face greater barriers to accessibility than those with other kinds of disabilities. For instance, in North Haven, a child respondent with autism rated several locales more favorably than another child respondent with a physical disability. However, no other insights emerged from our study of these data. Given the small number of respondents for each municipality and the wide variability of ratings within any particular town or city, we could not draw from these accessibility ratings credible conclusions about the inclusiveness or accessibility of any city or town as a whole.

We also examined the overall community ratings from the selected cities and towns. We found that there was just one community (Mystic) in which the average rating was 5.0. There were only two respondents from Mystic, both adults, and they each gave the town the highest possible rating overall in spite of the fact that they identified some specific settings as <u>not accessible</u>.

<u>Ratings of Three Real Choice "Model Communities"</u>

Among the three Real Choice designated "model communities," Groton received the most favorable response, with an average rating of 4.1 from 9 respondents. The Groton respondents were all adults between 22 and 64, representing a diversity of disabilities (physical, autism, visual impairment, psychiatric, and others). Not one of these respondents rated any of our 7 selected venues as <u>not accessible</u> and a minimum of 6 of the 9 rated each one of them as <u>fully</u> accessible.

The other two Real Choice System Change project model communities were not viewed as favorably as was Groton. The mean ratings for Bridgeport and New Haven were both below 3.0. Three of Bridgeport's 11 respondents rated the public beaches and parks as not accessible. (No other venues were rated as inaccessible by more than one respondent.) The beauty salon/barbershop, post office, and place of worship received the largest number of respondents stating they were fully accessible (8 to 9 out of 11). In overall ratings, the Bridgeport respondents had widely divergent views. Two of them rated the community a <u>5</u>, while two others rated it as a <u>1</u>, and the remainder were spread across all possible ratings. Adults with psychiatric disabilities could be found at both ends of this spectrum.

Among New Haven's nine respondents, just two settings (town office and public beaches and parks) drew single responses of not accessible. The settings rated fully accessible by the largest numbers (7 or 8 out of 9) were the post office, the library, and the health care provider. Unlike in Bridgeport, the New Haven respondents were not as spread out across the spectrum in their overall ratings of the community. The only two child respondents rated the community a 3 and 4, while the overall lower rating was a result of low scores from several of the adults.

Insufficient Evidence to Rank the Accessibility of Communities

We hoped that these summary ratings together with the ratings of specific settings within communities would tell us what communities were creating a stronger framework for supporting the full participation of individuals with disabilities compared to others. However, the larger lesson we take away is that accessibility and participation vary more according to the individual than according to the "community" at large. Also, impressions about one's community reflect realities that extend to larger, quality-of-life issues over which the leaders of a municipality have little or no control. Respondents who were not employed gave less favorable ratings to their communities, as did those who didn't drive. Children who answered the survey (that is, their parents) were more likely compared to adults to rate their home community more harshly (giving more 1s and less likely than other age groups to give a 5.). Respondents from the five urban centers were over-represented among those who rated their communities a 1 and under-represented among those who rated their communities a 5.

When a diverse group of respondents converge on an impressive rating above 4.0, as in Groton, we feel confident that many consumers with disabilities are having positive experiences in that community. Only one community besides Groton received an average rating of 4.0 or above based on five or more respondents: Meriden, with seven respondents and an impressive mean rating of 4.4. Although this is not conclusive, it certainly suggests that some positive efforts toward accessibility and welcoming of individuals with disabilities are being made. On the whole, however, we cannot credibly rank or draw conclusions about the accessibility (physical, programmatic, or otherwise) of different communities based on these data.

ELECTORAL PARTICIPATION

The U.S. Census reports that in the November 2002 election, 70% of the eligible population of Connecticut was registered to vote. Those actually voting made up 67.5% of those registered, which could also be framed as 47.5% of the U.S. citizens over 18, or 44% of the entire state population over 18. The Harris survey[16] found that 78% of persons without disabilities reported that they registered to vote in the 1996 Presidential election and that 62% of persons with disabilities registered to vote in that same election.

We asked respondents aged 18 and over to indicate if they voted, if they considered that the polls were accessible, and (if they did not vote) if they wished to vote. (We did not ask about registration but only about voting, and we asked in the present tense, “do you vote?” rather than asking about a specific election already held.) Figure 9 displays the results of some of our questions related to voting.

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[16] Harris Interactive (2000). Community Participation Survey.

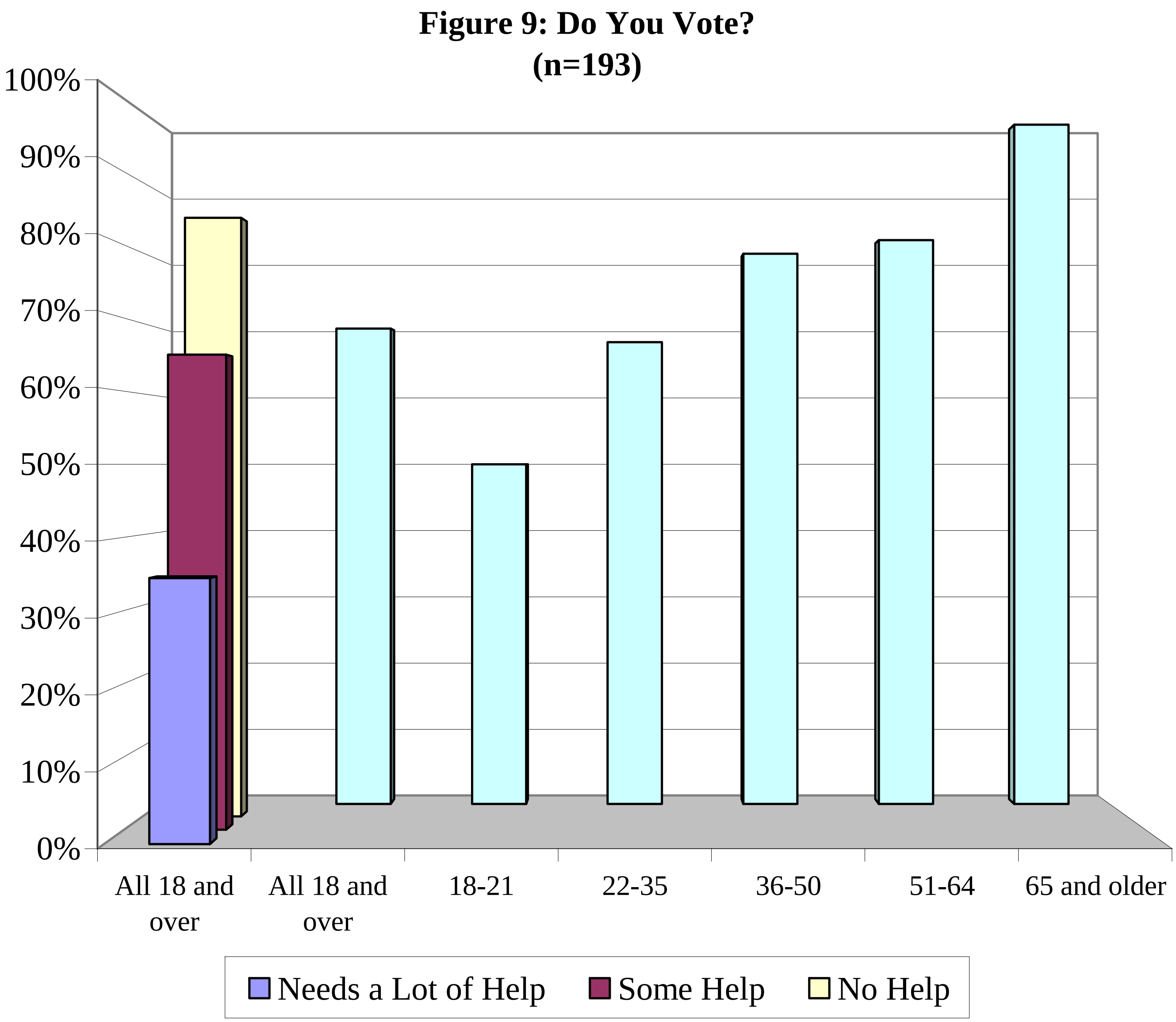
Figure 9: Do You Vote?
(n=193)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
All 18 and over
All 18 and over
18-21
22-35
36-50
51-64
65 and older
Needs a Lot of Help
Some Help
No Help

Figure 9 displays the responses to the question, "Do you vote?" A full 70% of those who found this question to be applicable answered yes. This included 50% of the 18 to 21 year olds and an increasing percentage across the older age groups, climbing from two-thirds (68%) of the 22 to 35 year olds all the way to 100% of respondents aged 65 and older. Because these percentages are so high, we have to conclude that both sample bias and bias created by the construction of the question are implicated. In other words, respondents who answered our survey are more likely than their peers to be voters (sample bias). Also, anyone who has ever voted could honestly answer yes to the question, "Do you vote?" (question construction bias) as opposed to, for example, "Did you vote in the November 2000 presidential election?"

Although the proportions of voters were strong everywhere, they were less robust in the five large cities (67% voted), more so in the smallest towns (76%) and strongest in the large towns/small cities (81%).

As Figure 9 indicates, voting participation declined considerably for those who reported needing a lot of help for daily activities. In our sample, 85% of those who reported not needing help voted, 65% of adults who needed some help voted and just 35% of those who needed a lot of help voted.

We asked all adult respondents if the polls were physically accessible and also user-friendly. Among respondents with physical disabilities, one-third (34%) reported that they were not physically accessible. Among those with all other disabilities, only half as many (17%) believed their polling stations to have problems with physical accessibility. Still, 85% of those whose primary disabilities were physical reported that they voted. Also, 80% of respondents across all disability categories stated that the polls they used were "user-friendly."

The only primary disability that appeared to be strongly associated with not voting was autism. Just one of seven adult respondents with autism answered yes to the question about voting. Just one of the non-voters with autism indicated that he or she would like to vote.

PUBLIC SCHOOL PARTICIPATION

We asked respondents to address several questions related to enrollment in a public K-12 educational program. Our survey also asked those enrolled about whether respondents "take a bus to school," whether they spent at least 80% of their school day with peers without disabilities, and whether they engaged in extracurricular activities with peers.

Attendance at K-12 Program

There were 56 child respondents from ages 5 through 21 who responded to this series of questions. Of these, 87.5% (or seven out of every eight) participated in K-12 programs. This included 94% of those ages 5 through 12, 79% of those 13 through 17, and 78% of those 18 through 21.

The primary disability types of the respondents reported as "not enrolled" in a K-12 program[17] included two with psychiatric disabilities (one adolescent and one young adult), two with autism (one elementary-aged student and one young adult), one elementary-aged student with visual impairment, and one adolescent with hearing impairment. There did not seem to be a direct correspondence between those who needed "a lot of help" with daily activities and those who were not enrolled in K-12 programs. Between ages 5 and 12, over 95% of the children who needed a lot of help were enrolled in a K-12 program. Between ages 13 and 17, over 85% of those who needed a lot of help were in K-12 programs. In the 18 to 21 age group, 60% of those

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[17] There was one adolescent reported as having a "developmental delay," but this cannot be accurate because that is a special education category restricted by federal law to children eight years old or younger.

who needed a lot of help were enrolled in K-12, but this was based on a minuscule sample of just five students.

Inclusion on School Bus

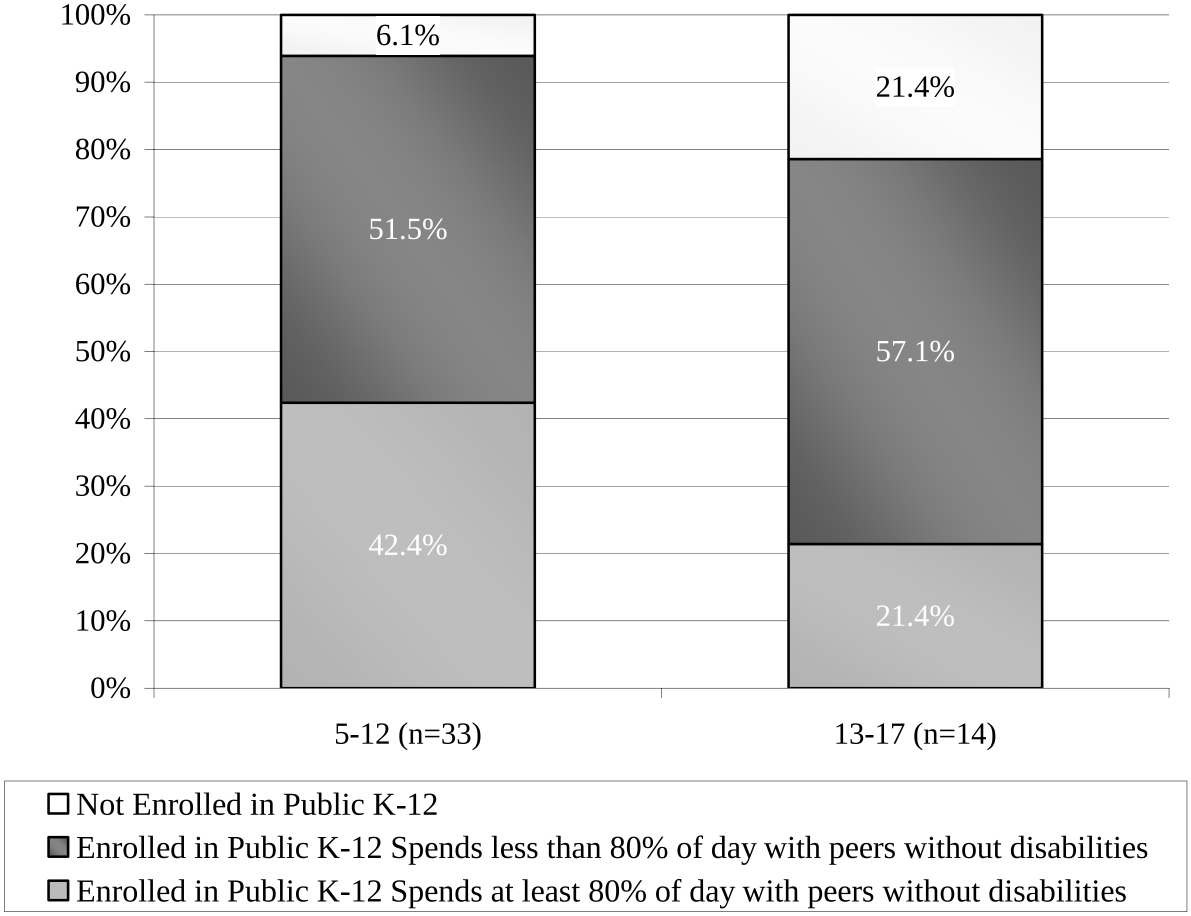
We found that nearly two-thirds (64%) of 53 respondents who said they were enrolled in a K-12 program rode a bus to school. Among the remainder, it seemed that a few preferred other options (e.g., "walks to school"), but most would have used the bus if the district policies and practices had facilitated this. In some cases, there was a lack of specific supports that parents felt were needed (e.g., seat belts, one-to-one aides, someone to take responsibility for administering epinephrine if the circumstances required it). One parent wrote, "I feel safer driving my child… There were two incidents… concerning… special needs children being left on a bus." One parent attributed her choice of an alternative transportation arrangement to the attitudes of peers: "the other kids in the neighborhood would not get on the bus with my child." She did not indicate whether she sought help from the school in addressing this problem before withdrawing her child from bus services.

In other cases, it wasn't a matter of specific supports that were lacking but of overall school policy. For instance, regular school buses were not equipped to carry passengers with wheelchairs. Or, as one parent stated, "We were not given the opportunity to take the regular bus, I was told my son must take the special needs van". Another parent was "not sure why" her child did not ride the regular school bus. Seemingly, she too had received the message that the "special bus" was the right one for him.

Involvement with Typically Developing Peers in Classroom and Extracurricular Activities

We also asked if the respondent spends "at least 80% of the school day with peers without a disability." Figure 10 displays the responses to this question.

Figure 10: Proportion of Time Spent with Typically Developing Classmates



We had 18 respondents from ages 5 through 21 who answered yes. This comes to 37% of those in this age range who stated they were enrolled in a K-12 program, or 32% of all respondents from ages 5 through 21. However, as Figure 10 reveals, these overall percentages mask stark differences in the responses of those in elementary school compared to middle or high school. A robust 42% of respondents from ages 5 through 12 spent at least 80% of the day with typical peers, but only half as many (21%) did so from ages 13 through 17.

It appears that our child respondents were included with peers less frequently, on average, than were special education students as a whole. The Connecticut State Department of Education reported on this subject to the federal Department of Education[18] covering the school year, 2002-2003. With respect to participation in least restrictive environments (all qualifying special education students from 3 through 21), they reported that 55.4% spent 79% or more of their time in regular classes with typically developing peers.

Looking at our data by disability types, the respondents most likely to spend their day with typical peers were those with learning disabilities (5 out of 6). Those least likely among our respondents to be included with typical peers were those with physical disabilities (2 out of 11), autism (5 out of 14), and cognitive disabilities (0 of 2). These data are consistent with the findings of the Connecticut State Department of Education. The agency reported that the students most likely to spend 79% or more of their time in regular classrooms were those with speech or language impairments (70.1%) and learning disabilities (62.5%). At the other end of the spectrum, among youngsters with intellectual disabilities, the proportion that spent 79% of the school day with peers was only 11.7%. Students in all other disability categories fell in between.

A higher proportion of our respondents stated that they participated in extra-curricular activities with peers without disabilities: 53% of those in K-12 programs, or 46% of all respondents ages 5 through 21. We anticipated that the proportion indicating they participated in extra-curricular activities would increase with age, due to more activities being available at middle school and high school than for younger children (for typically developing peers as well as for our respondents). However, contrary to our expectations, the proportions were stable

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[18] Connecticut State Department of Education (March 2004). Part B Annual Performance Report. P. 4.14.

across the years in school up to age 18. Among respondents ages 5 through 9, 54% said they were in extra-curricular activities with peers. This proportion remained almost identical (56%) for respondents ages 10 through 12, and rose a bit to 64% for the adolescents, ages 13 through 17. Participation with typical peers in extra-curricular activities dropped much lower for the 18 through 21 year olds (29%), most likely due to their participation in employment and transitions to independent living, combined with the unavailability of typically developing peers engaged at that age in extra-curricular activities.

CONCLUSIONS

Although we recruited our sample without any pretense that it would be random or reflective of statewide population patterns, the pool of adult respondents who answered our survey was in many respects remarkably representative of Connecticut residents with disabilities. A disproportionately high response from middle-aged individuals with psychiatric disabilities and an absence of individuals of Asian background were the only factors that skewed the profile of the adult respondents somewhat. The same was not true of the child respondents. A disproportionate 30% of the child respondents had autism, nearly two-thirds of the pool of respondents under age 18 needed a lot of help with daily tasks, and they were much more likely (compared to the Connecticut population or the adults in our sample) to live in the smallest towns and much less likely to live in the state’s five urban centers. In addition, the child sample was also missing Asian-American respondents. We present below some interpretations, conclusions, and issues for further exploration, starting with a few points related to children with disabilities in Connecticut, and then examining the broader array of issues affecting individuals with disabilities across the life span.

PUBLIC SCHOOLS AND CHILDREN'S ISSUES

In the eyes of many adult respondents, the public schools did not show up very strongly as accessible. In contrast, most current users of the schools found them to be fully accessible. (The accessibility index for schools among all survey respondents was 3.2 but among respondents aged 21 and under, it was 6.5.) We interpret this to mean that many schools have moved in the right direction in recent years. Many adults with disabilities, however, must continue to look back on their years in school with misgivings.

Our survey also examined the accessibility of two other child-oriented community settings: playgrounds and childcare. Playgrounds received a mixed response among child respondents, with one out of six (16%) rating their playground <u>not accessible</u> and half (51%) reporting them as <u>fully accessible</u>. On the other hand, more of them rated daycare as <u>not accessible</u> (28%) than <u>fully accessible</u> (22%). This should be a red flag for those involved in funding, licensing, and training for staff in childcare centers and family childcare homes.

Looking beyond the question of accessibility to full-fledged inclusion in public school classrooms, only about one-third of the child respondents were spending 80% of their school day in classrooms with typical peers. They were especially unlikely to do so if they had physical disabilities, autism, or cognitive disabilities. Our child-sample was strongly representative of families with children who had very substantial disabilities (i.e., nearly two-thirds needed a lot of help with daily activities, and very few were placed in the milder special education categories of learning or speech/language disabilities).

The fact that these children were participating in regular K-12 programs to a great degree (nearly 90%) can rightly be seen as a historical watershed and is very affirming of the efforts that families and educators have made over the past generation to create a unified public school system that serves all children. At the same time, the reality is that the majority of them were not fully included in the regular K-12 curriculum. This was especially true among our adolescent respondents. Because our numbers were small and not randomly drawn, we do not know if these responses represent a more generalized reality, but it is a finding that deserves a fuller examination.

The fact that most young respondents with disabilities - over half of elementary-aged youth and nearly two-thirds of adolescents under 18 - were spending time with typical peers outside the classroom is welcome news. We do not assume that most of these inclusive venues were "extra-curricular activities" in the formal sense (i.e., programs sponsored and run during out-of-school hours by school teachers) even though we used that lexicon in our survey. The proportion of children reported to be attending these programs with peers in the elementary grades (and the lack of increase from younger children to older children) indicates to us that respondents were reporting on community-based activities as well as school-sponsored extra-curricular programs. Nevertheless, given the level of support required for the children who responded to our survey, their widespread participation with peers in non-academic activities has to be viewed as a hopeful trend.

EMPLOYMENT

Our Connecticut sample shows a substantially higher percentage of persons gainfully employed than among a comparison national sample. Looking across the adult age spectrum from 18 through 64, we found 58% employment compared to 32% of the Harris sample. This was the case even though the proportion of adults in our sample who needed a lot of help for daily activities (16%) was close to the percentage in their sample (19%) that needed help with basic needs.

Respondents with hearing impairments, cognitive (intellectual) disabilities, physical disabilities, and autism were among those helping to bring up the rates of employment. In addition, nearly half (47%) of those with psychiatric disabilities reported that they were employed. On a more sobering note, the percentage of all adults ages 18 through 64 working <u>full-time</u> was below 18%. Among our largest pool of working-age respondents, those with psychiatric disabilities, fewer than 7% were employed full-time. Even among younger respondents under 36 (where there was no disproportion of respondents with psychiatric disabilities), the rate of full-time employment remained below 20%. It would be useful to know how many of those working part-time would prefer to be working full-time.

The Harris survey asked an interesting question related to employment that we did not: "Does a health problem, disability, or handicap keep you from participating fully in work, school, housework, or other activities?" The population who reported they were unable to work (or limited in their work) due to their disabilities was a sizable 43%. They also found that two out of three unemployed people with disabilities (67%) would prefer to be working.

In contrast, we found that only 43.5% of those who were unemployed appeared to wish to be working. In fact, the number of Connecticut respondents' unemployed and <u>not seeking employment</u> slightly exceeded the numbers who were unemployed and <u>seeking employment</u> at ages 36-50 and 51-64. The higher proportion employed together with the higher proportion of seemingly voluntarily unemployed adult respondents leads us to wonder if Connecticut residents with disabilities lack the information regarding programs available to help people with significant disabilities keep their Medicaid (Title XIX) and other benefits while they work. Another possible explanation is that Connecticut residents may have different (perhaps higher) expectations than the national sample about the accommodations and supports employers will supply when they do enter the labor force. This tentative conclusion was also buttressed by the finding that among younger adult respondents ages 22 to 35, the employment rate soared to 86% among respondents who needed a lot of help with daily tasks. This exceeds the national employment rate for persons <u>without</u> disabilities as determined by Harris (81%). This surely represents sample bias (i.e., those who responded to our survey were more likely to be in the work force than others from the same subgroup who did not take the survey). Still, it suggests that among younger adults with significant disabilities who received education and transitional support through the provisions of IDEA as amended since the late 1980s, there has been some noteworthy success in gaining entry into the work force.

COMMUNITY ACCESSIBILITY AND INVOLVEMENT

Our data related to community accessibility permit us to draw only a few modest conclusions. The two settings that drew the highest accessibility ratings across the state, including good ratings from the sub-sample of persons with physical disabilities, were the supermarket and the bank. It is comforting to know that in transactions involving two of life's necessities—food and finances—most Connecticut citizens are finding venues with adequate receptivity to their needs. However, among other institutions - including vitally important public institutions such as the library, town hall, public parks, and post offices - there seems to be a lot of variation from community to community.

When it comes to active participation within their local communities, respondents in our sample showed equal or higher levels of involvement in numerous aspects of community life compared to the respondents with disabilities that answered a national survey. In some areas, such as involvement with local service organizations and in volunteer work, the participation levels of our respondents were even higher than the national Harris samples of persons <u>without</u>

disabilities. We can infer that on average, individuals responding to our survey were more highly engaged and community-minded than a random selection of their peers. In addition to reporting higher levels of participation in specific arenas, the Connecticut respondents viewed themselves compared to their counterparts with disabilities in the other sample as more involved, more satisfied, and significantly less dissatisfied. The Connecticut respondents also were more likely than either national sample to believe they were "valuable and contributing members" of their communities (63% of our sample endorsed this opinion versus 49% of persons with disabilities in the other sample and 55% of those without disabilities).

However, in spite of their level of involvement and pride in being contributing members of their communities, nearly two-thirds of our Connecticut sample felt that they were not invited to give their opinions and over half felt isolated and that they were left out of things. These results are chastening to anyone who has been working to secure opportunities for full and active participation by persons with disabilities. We need to know what kinds of signals convey to these consumers that their opinions are not needed or wanted. What kinds of attitudes or practices make them feel isolated? What continuing barriers lead them to conclude that they are "left out" of meaningful aspects of community life? Can these shortcomings be redressed by systemic and formal changes within organizations, businesses, and government? Or are they mostly about informal attitudes, stereotypes, and prejudices that persist even after the adoption of formal policies and practices that support inclusion, consumer empowerment, and self-determination? It will require a more qualitative approach (e.g., in-depth case studies or interviews) to fully comprehend this finding and to address the very real challenge that it lays bare.

ELECTORAL PARTICIPATION

One measure of full participation in the civic life of our country is access to and use of the ballot box. The percentage of respondents who said they voted in elections was extraordinarily high (probably even higher than any given election day reality, as we noted in our discussion of the findings). Most of those who did not vote indicated they had no desire to do so. Nonetheless, local officials should take note that some respondents who wished to vote were not doing so. The adult survey respondents who reported that they did not vote but would like to vote had diverse disabilities, were dispersed across all five regions of the state, and resided in all sizes of communities. More than half of them drove, and only one needed a lot of help with daily activities. The only thing they all had in common (aside from identifying themselves as White/Caucasian) was that each rated their city or town as 3 or worse for overall accessibility and inclusion. (Several rated their communities as a 1 or a 2). Thus it appears that the route to improved voting participation among persons with disabilities may not come from specific actions taken by electoral authorities, but from steps taken by the municipality to signal in a broader sense that the contributions of persons with disabilities are welcomed and desired.