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ASSESSING SERVICE EQUITY AND PROGRAM EFFECTIVENESS IN THE
TENNESSEE DIVISION OF REHABILITATION SERVICES PROCESS

A Dissertation
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Sally Ann Wise

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ABSTRACT

This study was done (1) to determine whether there was bias against of Tennessee Division of Rehabilitation Services clients, (2) to determine whether cost/benefit analyses (in terms of expenditures and client incomes at closure) revealed adequate use of funds, and (3) to ascertain counselors' perceptions of service equity and effectiveness as well as recommendations for improving service delivery.

Questionnaires were sent to all rehabilitation counselors employed by the Tennessee Division of Rehabilitation Services in July 1985 to determine the frequency of specific counselor behaviors and to ascertain their perception of the effectiveness and equity of the program. Computer data from the official counselor reporting system was used to determine the amount of income at closure, the types of disabilities served, and the work statuses of rehabilitants. Computer data was also used to determine expenditures, the number of rehabilitants earning minimum wage and the number of SSDI/SSI clients earning SGA.

It was determined that bias existed in terms of counselor creaming (ignoring manual guidelines and choosing only those clients with the greatest and easiest potential for rehabilitation in order to create impressive statistics) and counselor bias from maintaining stereotypical beliefs regarding clients due to their gender, race, or severity of disability classification. The cost/benefit analyses indicated that all client subgroups' incomes

improved substantially from application to rehabilitation. The average cost of rehabilitation per client is generally repaid to taxpayers in less than five years of the rehabilitant's employment. Eighty percent of the counselors who responded to the questionnaire indicated more effective services would be provided if they did not have to worry about meeting the quota for Status 26 closures. Recommendations were made for enhancing the rehabilitation process as well as for areas of future research.

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INTRODUCTION

Federal and state agencies have formally supported the provision of services through Rehabilitation Services for individuals with specific disabilities that create functional limitations for the individual. There has been recent growing interest in assuring that services be provided sufficiently, effectively and justly. The goal has become that of providing quality services while maintaining or reducing current costs. Few studies, however, have examined the provision of services in terms of quality and outcome.

Three previous studies reported relationships between the rehabilitation process and the demographic variables of race and gender. These studies have examined (1) the relationship of counselor planning of client rehabilitation to race and gender (Steger, 1981), (2) the relationship of race and gender to salary and occupation at closure (Malik, 1973/1974), and (3) the relationship of race to the provision of services during the rehabilitation process and to client salary at closure (Atkins and Wright, 1980).

This study examined the provision and outcome of services that have been offered to individuals with disabilities who have received services through the Tennessee Division of Rehabilitation Services and have been closed as successfully rehabilitated. The purpose was threefold: (1) to determine whether there has been discrimination against subgroups of clients, (2) to ascertain counselors' perception of service equity and effectiveness, and (3) to determine whether or not tax dollars were applied beneficially.

CHAPTER I

STATEMENT OF THE PROBLEM

At a training conference for Tennessee Rehabilitation Services counselors, speakers focused on the issue of quality of services. Counselors, obviously, need to retain the goal of rehabilitating as many clients as possible. They also need, however, to assure that services have been effective in creating a positive vocational change for each individual client.

At the conference Cornett (1984) affirmed the focus of rehabilitation as always having been and remaining a one-on-one relationship between client and counselor with the goal of enabling the client to become gainfully employed. However, he expressed concern that counselors have become satisfied with meeting the minimum requirements rather than striving for excellence. He acknowledged that a legitimate "homemaker" closure (i.e., a person whose principal activity is keeping house for his/her family) meeting the primary goal, needs, and abilities of the client is an appropriate rehabilitation goal. Cornett stated it is not enough, however, to close a client's case in this category simply because alternatives for employment seem to have been exhausted. Moreover, he condemned the "phantom job" that does not represent actual competitive employment appropriate to the individual client but reflects quick client turnover without provision of needed services. His challenge was to realize the concept of quality services.

Also at the conference, Hanks (1984) discussed the fiscal and programmatic accountability that counselors must now consider when

providing services. He expressed concern that sheltered employment (i.e., employment in a non-competitive workshop setting earning less than minimum wage) has become a dumping ground for counselors who want quick and easy case closures without considering clients' interests and abilities. Moreover, Hanks recommended that rehabilitation services be evaluated to make services more appropriate and to make certain that counselors persevere in serving individuals with severe disabilities.

Purpose of the Study

McGowan and Porter (1967) and Lynch (1981) presented the philosophy of rehabilitation as advocating,

that all persons have the right to earn a living and contribute to society, while society has accepted the obligation to restore persons with disabilities to their highest level of functioning—physically, socially, mentally, vocationally and economically. (Lynch, p. 113)

The Tennessee Division of Rehabilitation Services has the assignment of providing services to eligible individuals with disabilities to enable them to become competitively employed whenever feasible; or to function as a homemaker, unpaid family member, or sheltered workshop employee when these are more appropriate goals. Furthermore, the agency is directed to administer services in such a manner that "no individual shall be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination on the grounds of race, color, sex, handicap or national origin" (as stated on the back of the Individualized Written Rehabilitation Program, see Appendix A).

Grobe (1981) provided ten criteria for determining whether clients are successfully employed as a result of rehabilitation services:

1. Client and employer are satisfied.
2. Client is maintaining adequate interpersonal relationships and acceptable behavior in the job environment.
3. Occupation is consistent with the client's capacities and abilities.
4. Client possesses acceptable skills to perform or continue in the work satisfactorily.
5. Employment and working conditions will not aggravate the client's disability in the job setting and will not jeopardize the health and safety of himself or others.
6. Wages and working conditions conform to state and federal satisfactory requirements.
7. Employment is regular and reasonably permanent.
8. Client receives a wage commensurate with that paid other workers for similar work.
9. The job provides for upgrading and advancement within a reasonable period of time.
10. The wage received is sufficient to enable the client and his family to obtain a minimally sufficient standard of living "as defined by the poverty level."
(pp. 24-25)

Whitten (1974) explained that the rehabilitation laws are primarily aimed at employment. However, the Rehabilitation Act of 1973 (P. L. 93-112) acknowledged that rehabilitation goals may not always include employment. This is to enable severely disabled persons to be assisted in reaching maximum functioning other than economically. The law stated that the severely disabled should receive the higher priority. However, the funding has not always been appropriated to enact the various rehabilitation laws (Hills, 1972).

The Tennessee Division of Rehabilitation Services counselors have the goal of assisting eligible individuals with disabilities to receive the health care (mental or physical), training, and/or guidance necessary to gain employment. However, there are instances when it is

also appropriate to enable individuals to work in the family business or on the family farm or to develop homemaker skills in order to release other family members for employment.

The counselors are given annual quotas for closing cases as successfully rehabilitated (i.e., having worked for 60 days or being homemakers/unpaid family members). For fiscal year 1983 the average was 37 cases (counting the 118 districts in Tennessee that made up Vocational Rehabilitation at that time). In order to meet overall state quotas, counselors serving a general caseload (i.e., serving clients with a variety of disabilities) were given an annual quota of 60 successfully rehabilitated case closures (Status 26). Counselors with a specialized caseload (i.e., serving a single disability category) were expected to close annually approximately 40 cases as rehabilitated. For fiscal year 1984 the goal for the average number of closures across the state was 25. Rehabilitation Services counselors have been instructed by central office staff to insure that 45% of the successfully rehabilitated clients are classified as severely disabled. For fiscal year 1983 the counselors met this goal and 91% of the overall goal (severely disabled and non-severely disabled combined). Rehabilitation staff have expressed concern that the quota system may result in providing only short-term service delivery to those clients who already have the greatest potential for employment. This has led to further concern that this would be at the expense of in-depth services to those individuals who have the greatest need for the program.

Schenzinger (1981) expressed concern that less than meaningful services are offered while Cooper, Harper, and Davis (1980) expressed concern that less than minimum wage is used as an acceptable criterion for non-severely disabled clients. The "DRS Statistics for FY 82" reported that for the 4,795 Tennessee Rehabilitation Services clients closed as successfully rehabilitated in fiscal year 1982, the average weekly wages at closure was \$122. This meant an average increase of \$107 per week from the average wage at referral. Of the 3,922 rehabilitated clients in fiscal year 1983, the average weekly earnings had risen to \$133.42. The average weekly income of clients classified as Severely Disabled (SD) was \$128.41 (M.I.S. 2, 1983), approximately 96% of that for clients classified as non-severely disabled (NSD). (See Appendix B for the criteria for identifying clients as Severely Disabled.)

However, client income at closure is not the only concern for rehabilitation practitioners. Job satisfaction resulting from appropriate placement is another criterion in the rehabilitation program. This is usually the result of jointly establishing the vocational objective that meets the client's individual needs, abilities, and goals.

Steger's (1981) research was conducted to detect counselor bias and influence in the establishment of the client's vocational objective. Fictitious case studies were presented, changing only the gender of the client (as the independent variable), to counselors to determine if different vocational objectives were suggested. It was found that client gender covaried with the counselor's suggested vocational

objectives. Malik's (1973/1974) study evaluated whether race and gender covaried with the outcome of rehabilitation services, both in job classification (blue collar versus white collar) and salaries. Malik found that the actual jobs in which clients were placed were influenced by the client's race and gender. Nonwhite clients earned less money in comparable areas of employment and females earned less than males in comparable employment. Atkins and Wright (1980) reported differences in patterns of services for black clients and white clients, particularly in the area of training. They reported that white clients received higher education than blacks, the proportionate share of case expenditure increase was higher for white clients than black, and the salary at closure was more often at a higher level for white clients than black clients.

After reviewing these studies, this investigator became interested in examining Tennessee's present rehabilitation process and developed three primary objectives. The first was to determine if there is discrimination against subgroups of clients. (Discrimination may or may not be consciously intentional. According to Blumrosen [as noted in Malik, 1973/1974], "It is often a mental reflex, rather than a conscious conviction, and as such cannot be isolated, quantified, and neutralized" [p. 1]). Discrimination could be due to both counselor creaming (i.e., serving only easily and quickly rehabilitated individuals, see Appendix C for definitions) resulting from attempts to meet the Status 26 closure quota and counselor bias in stereotyping subgroups of clients by gender, race, and severity of disability classification. The second objective was to determine if a cost/

benefit analysis would reveal adequate use of the tax dollars assigned to rehabilitate individuals with vocationally handicapping conditions. The third objective was to ascertain counselors' perceptions of service equity and effectiveness as well as recommendations for improving service delivery. (The null hypothesis for any statistical tests in this study was that there is no significant difference between Rehabilitation Services client groups.)

Need for the Study

At present the agency's methods of accountability include the total number of clients served, number of clients rehabilitated, case expenditures, and salaries at closure. Counselors include in each successfully closed case a "Counselor's Evaluation of Preparatory Services" outlining the services provided, the client's benefit from services, and the outcome of services in terms of salary and occupation. However, the primary measurement of accountability is the number of Status 26 closures per district indicating that clients are gainfully employed, in sheltered employment, or unpaid family members/homemakers. This study can be used to develop criteria for examining the quality of rehabilitation services in terms of services most often received by successfully rehabilitated clients and cost/benefits to clients. Furthermore, it can be used to evaluate staff perceptions of the role of the program in vocationally rehabilitating clients.

Moreover, the information from this study partially meets the 1984 Amendments requiring the collection of individual data for the annual

report required by the Rehabilitation Services Administration including race, gender, earnings before and after services, and cost of services. The Division of Rehabilitation Services needs to evaluate its current process to determine whether appropriate steps have been taken to help clients become "job ready" and to provide skills that last a lifetime, not just 60 days (the current time frame for closures). Rehabilitation Services, furthermore, needs to meet clients' individual needs and enable clients to become long-term taxpayers, thereby replenishing the money spent for their rehabilitation and providing tax funds for other clients. This study can be one method of determining ways to meet these agency needs.

If race, gender, type of disability, and/or severity of disability classification are reflected in service delivery and outcome, the results of the study can be used for counselor in-service training towards better understanding client uniqueness within broad categories of group definition. The study can also be helpful in weighing quality versus quantity when examining the influence of the quota system on service delivery.

The possibility exists, also, that the study can be used to justify past expenditures as well as substantiate the need for additional funding if more money is needed to purchase additional training and/or restoration for clients. Thus, the research can demonstrate accountability, serve as a learning process to improve client services, and reaffirm agency goals and commitment to individuals with disabilities.

Assumptions and Limitations

Assumptions

One assumption of the program is that services are designed to meet the individual strengths, weaknesses, aptitudes, and interests of each client. Another is that job titles are expected to reflect training when it has been provided. An additional assumption is that subgroups by race and gender will earn approximately minimum wage (\$134 a week) at the time of closure as successfully rehabilitated. (The average earnings of all rehabilitated Tennessee clients in fiscal year 1983 was \$133.42.) The Social Security Administration designates \$300 (\$610 for SSDI Blind) a month as Substantial Gainful Activity (SGA) for former recipients while Rehabilitation Services designates \$70 a week as Substantial Gainful Activity.

Since the title of the Agency was changed in 1983 from Vocational Rehabilitation to Rehabilitation Services, both titles are used interchangeably. Various documents in the present organization carry either title.

Limitations

As of fiscal year 1982, the number of homemaker closures was to be reduced to less than 15% and for fiscal year 1983 to be reduced to 10%; and a single service was no longer provided unless it was directly related to remunerative employment. Also, in 1983 dental cases were to cease and gynecological services were to cease for homemakers. In 1984 remunerative employment was removed from the criteria for services. Furthermore, in 1983 Services for the Blind

became part of Rehabilitation Services. Thus, the rehabilitation populations were different for fiscal years 1982, 1983, and 1984.

One problem in serving homemaker clients in Tennessee is that there are only vague terms used to define homemaker as a gainful occupation: "work activities must be performed by the individual and there must have been benefits derived from VR services which improves the client's ability to function in these tasks" (Vocational Rehabilitation Program Manual [VRPM] 1541.16). This goal could more easily be evaluated by criteria such as those used by the West Virginia Rehabilitation Center as described by Guthrie, Crist, Sieniski, and Wells (1981). These skill areas are meal planning, marketing, meal preparation, dishwashing, bedmaking, laundry, house cleaning, child care, and mending. (See Appendix D for a more detailed outline.)

The investigator arbitrarily reduced specific disabilities to broad categories used by the agency. The only racial comparisons were black (21% of the open cases in FY 1985) and white since the remaining groups make up less than 1% of Tennessee's total population.

The researcher added the variable of severity of disability because individuals may tend to have certain beliefs and expectations of disability categories rather than see individuals with disabilities as having their own unique assets and limitations. "Severely Disabled" is a broad category that not only includes an exact cut-off point as the actual condition of the client's disability (such as an I.Q. score of 39 or below designating the client as severely disabled), but also groups a wide range of dissimilar people together. Furthermore, technicalities may group clients into severely disabled versus non-severely disabled

categories. For example, all Supplemental Security Income (SSI) recipients are classified as severely disabled by the Tennessee Division of Rehabilitation Services. However, Supplemental Security Income (SSI) recipients' eligibility is based on financial status as well as disability. Therefore, there are non-Supplemental Security Income (SSI) Rehabilitation Services clients with similar disabilities whose income is the only criterion that prevents them from receiving SSI. These clients might not be classified as severely disabled by Rehabilitation Services only because they do not financially qualify for SSI payments. Similarly, they might not have earned enough credits to qualify for regular Social Security benefits, another criterion for severe disability classification.

There is concern that the classification as Severely Disabled should not be used as a criterion for automatically providing a general repertoire of services because people within a broad disability category do not necessarily have the same functional limitations, needs, or assets. Some clients might have had more education, personal adjustment, higher income, etc., prior to rehabilitation services and, therefore, need less specialized services from the agency. Furthermore, as explained by the Rehab Group (1979), diagnostic definitions do not necessarily yield functional definitions since people with the same impairments do not necessarily have the same functional limitations. For example, a lawyer with a spinal cord injury might not suffer a work disability, while a construction worker with the same spinal cord injury might be totally work-disabled. Thus, in spite of clients meeting

criteria for the broad category of Severely Disabled, services still should be individualized according to the client's needs, goals, and capabilities. Therefore, while Severely Disabled is important as a classification, it does not require a specific preset service as a result of the severity of the disability.

In reading case records in which counselors designated clients as severely disabled, the investigator found that the designation was often very subjective in spite of existing official criteria (see Appendix B for criteria). For example, one client was designated as severely disabled because of obesity as well as having been in counseling for several months (neither of which is listed as an official criterion). However, the final decision for establishing eligibility and severity of disability is the responsibility of the individual counselor although national and state guidelines are to be used in making the decision. Therefore, the classification given by the individual counselors was the classification used for this study.

There are further limitations due to the investigator's inability to use client records for the study. It is not possible to count similar benefits since the computer records only purchased services or counseling and guidance provided by the rehabilitation counselors. Moreover, at present there is not a method for establishing a time frame for services or noting whether more than one service is offered at a time. Furthermore, there is no method of recording whether or not the original occupational goal listed on the Individualized Written Rehabilitation Program (see Appendix A) has been met. One further problem is the inability to note whether clients closed in "no income"

categories were actually performing homemaker duties or working in the family business or on the family farm, or just closed without a job. (See Appendix C for definitions.)

Due to the investigator's inability to use client questionnaires, it was impossible to determine whether clients agree that their needs and goals were met. (The investigator believes client participation in assessing quality of services and method of service delivery should be a vital part of the rehabilitation process and proposes a client questionnaire such as that shown in Appendix E.)

There are additional limitations in using self-report questionnaires in general. Since counselor questionnaires were used in the study, it is important to note Steger's (1981) warnings that self-report instruments are subject to faking (individuals may consciously or unconsciously respond according to their expectations of the investigator's views on the subject). Also, instruments designed to measure attitudes do not necessarily measure the actual behavior of the subjects. However, counselor questionnaires were used to supplement computer data to provide additional insight into the rehabilitation process since the researcher did not have access to client records. Hopefully, maintaining counselor anonymity reduced counselor faking on the instrument as well as relieved fear of administrative reprisal. Furthermore, the counselors were not informed that the researcher was looking for bias.

CHAPTER II

LITERATURE REVIEW

In examining the literature pertaining to the rehabilitation process and disabled individuals in general, it is important to consider three major aspects of Rehabilitation Services. These are (1) the legal precedents and societal expectations leading to our present program, (2) the government statistics reflecting the current status of individuals in our society who are limited by handicapping conditions, and (3) the general research regarding individuals with disabilities.

Historical Considerations

Legal Precedents

To understand the current rehabilitation process, it is worthwhile to examine the laws that have gradually expanded the program. These reflect the purpose and procedures for serving individuals in our society who have been hampered by mentally and/or physically disabling conditions.

In 1918 the Soldier's Rehabilitation Act was passed to provide aid to any soldier who could not work. Then, in 1920, the Civilian Vocational Rehabilitation Act (Smith-Fess Act) was passed to provide individuals with disabilities (i.e., physical defects or infirmities) vocational guidance, occupational adjustment, prosthetics and placement services. Later, in 1935 the Federal Social Security Act (P. L. 74-271) made rehabilitation a permanent program with continuous funding.

In 1935 the Randolph-Sheppard Act (P. L. 74-732) assisted the blind with employment by requiring that all vending stands in federal buildings be operated by the blind. The Vocational Rehabilitation Act Amendments of 1943 (Barden-La Follette Act) provided service to the mentally ill and mentally retarded as well as the visually disabled. Randolph and Minton (1980) explained that the program could then provide any service necessary to render a disabled individual fit to engage in gainful employment. The program provided physical restoration, therapy, hospitalization, transportation, occupational licenses, tools, and maintenance payments.

In 1954 the Vocational Rehabilitation Act (P. L. 83-565) provided financing for professional training, expansion of services and resources, research, and demonstration programs. Moreover, a system for prioritizing was established to cover situations when not all applicants could be accepted (usually due to limited program funding). In 1966 economic need was no longer the sole basis for all rehabilitation services. The Vocational Rehabilitation Act Amendment (P. L. 89-333) also provided for extended evaluation to determine whether or not services would benefit handicapped individuals. Funds were made available for construction of rehabilitation facilities and the improvement of sheltered workshops. Rehabilitation agencies were enabled to assist clients' family members also. Furthermore, the National Commission on Architectural Barriers was established to assist in making buildings more accessible and useful to the disabled.

The Vocational Rehabilitation Amendments of 1967 (P. L. 90-99) abolished the residence requirements which excluded from rehabilitation services persons who were otherwise eligible. Later, the Architectural Barrier Act of 1968 required accessibility in new public buildings built with federal funds. The Projects with Industry program was enhanced with the recruitment and training of handicapped individuals for public service employment. The Vocational Rehabilitation Amendments of 1968 (P. L. 90-391) guaranteed each state a minimum of one million dollars for client services. Furthermore, federal sharing was increased to 80%.

Also in 1968 "disadvantaged individuals" (i.e., any individual who is disadvantaged in his/her ability to secure or maintain employment due to physical or mental disability, youth, advanced age, low educational attainment, ethnic or cultural factors, prison, or delinquency records, or any other condition, especially in association with poverty, that creates a barrier to employment) became eligible for vocational evaluation and work adjustment. Problems such as delinquency and criminal offenses became "behavior disorders" and were considered criteria for services. Hills (1972) defined behavior disorders as characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community. Thus, the alcoholic, public offender, drug addict, and socially and culturally deprived were included in the program. However, professionals could not agree on a definition for "behavior disorder" and in 1971 the concept was dropped from the program. (Rehabilitation Services does not use prison and delinquency records as criteria. However, substance abuse is still

an eligibility criterion. Economic factors are still evaluated in terms of eligibility for maintenance payments, books, tools, and other services/goods purchased by the state of Tennessee. Schools now have the primary responsibility for disabled youth to age 22 or upon the student's voluntarily leaving the school system.)

The National Civilian Vocational Rehabilitation Act of 1920 and its amendments were incorporated into the Rehabilitation Act of 1973 (P. L. 93-112). The two main underlying themes were client involvement with the rehabilitation process and primary emphasis on services to the severely disabled. The Individualized Written Rehabilitation Program (see Appendix A) was introduced as a guide for each client's rehabilitation process. The act also placed greater emphasis on job placement and job maintenance. It provided for annual reviews of ineligible clients and provided affirmative action for the employment of the disabled.

The Rehabilitation Act Amendments of 1974 (P. L. 93-516) emphasized reporting and analyzing the reasons for determination of ineligibility and re-evaluating those individuals denied service. Title V of the act defined the civil rights of handicapped individuals and required equal opportunities in education and work. Furthermore, it required the least restrictive environment for educating handicapped children. Section 501 of Title V required affirmative action in employment in the executive branch of the federal government. Section 502 established the Architectural and Transportation Barriers and Compliance Board to ensure accessibility to urban transit systems as well

as public buildings and facilities. Section 503 required affirmative action in employment practices by contractors with federal contracts or sub-contracts over \$2500. Section 504 stated that no person could be excluded from, denied benefits of, or be discriminated against by any program receiving federal financial assistance due to his/her handicap. "The intent of Congress is that clients will be active partners in their rehabilitation, and that VR will emphasize services to the severely handicapped first" (Randolph and Minton, 1980, p. 7). Section 505 provided for remedies and attorneys' fees in action involving violation of the rights of handicapped individuals.

The Rehabilitation Extension Act of 1976 (P. L. 94-230) extended the Act of 1974 and increased funding. It also defined "severely disabled" as "an individual under a disability so severe as to limit his ability to function...."

In 1978 the legislative direction was toward strengthening the program for independent living as well as developing better interaction with the community and private sector. The National Institute for Handicapped Research (NIHR) and the National Council on the Handicapped were established.

The Rehabilitation Amendments of 1984 (P. L. 98-221) provided for cost-of-living increases and extended the state grant portion of the Rehabilitation Act. It established a separate authority for the Helen Keller National Center for Deaf-Blind Youth and Adults. It also established the National Council on the Handicapped as an independent agency within the federal government and charged it with the responsibility of reviewing federal programs to assess incentives or

disincentives for community based programs. Furthermore, the development of standards for evaluating existing independent living centers and projects with industry were required. The client assistance program was changed from a demonstration discretionary program to a formula state grant program. The Director of the National Institute of Handicapped Research was given the authority to test new concepts and innovative ideas and to allow grants for research and training centers. The Developmental Disabilities Assistance and Bill of Rights Act were extended.

Societal Expectations

It is important to consider not only the actual legislation regarding rehabilitation services but some of the expectations for the program. Hills (1972) explained that rehabilitation was promoted as an investment policy (i.e., a sound fiscal policy paying dividends in that taxes paid by rehabilitation clients more than cover the cost of their program) and a solution to social problems. Whereas social workers were seen as people who "aid and assist in making others give up their initiative and seek a lifetime of welfare" (p. 78), rehabilitation counselors were seen as "the force which aims at returning a measure of independence and self-support, reducing public dependency and assistance costs" (p. 78). Thus, the rehabilitation concept fit into the American work ethic. The assumption was "Work becomes an American virtue, the nation needs productive work, in fact a person 'owes' his country his productive work in return for its benefits. Disability brings costly dependence and social waste" (Hills, 1972, p. 83). Hills included in

his definition of productive work competitive employment, self-employment, homemaking, farm or family work, sheltered employment, and homebound industry.

Counselor Creaming

Before reviewing the topic of counselor bias, the effect of agency requirements on counselor productivity and resultant services to clients will be considered. Hills (1972) described creaming as the act of choosing only those clients with the greatest and easiest potential for rehabilitation, thus creating statistics that look good for the counselor and agency while ignoring other eligible clients.

Counselor-creaming bias can result from counselors' efforts to meet state and federal quotas for successfully closing cases (i.e., rehabilitating individuals with disabilities). It is important to note Hills' (1972) statement that the severely disabled, the poor, and racial minorities (often the same group) are more difficult and more expensive to rehabilitate. Since it is often almost impossible to obtain employment for these clients after expensive services such as training have been rendered, there are strong pressures to reject them as unfeasible before expenditures are made. (Since feasibility is an eligibility requirement in Tennessee, services may be denied if a counselor does not believe a client will be employed as a result of services.) Accepting the reality of creaming as a survival technique for counselors, Hills (1972) explained why counselors cream.

The professionals want their efforts to succeed. They want to be acknowledged and appreciated for their successes. In turn, they wish to get satisfaction, pleasure, prestige, and status from their work; money should also come. It is incongruous for

the professional counselor to expect these professional needs and aspirations to be fulfilled in working with the most difficult, suspicious, recalcitrant, ignorant, impoverished, and hopeless cases. (p. 146)

Furthermore, Hills (1972) quoted Young in stating

There is a tendency, as natural as it is evil, for most institutions to work not with those who need them most, but with those who are more likely to be successful showcases of their agency. But the overriding question must be: who are you in business to help? (p. 121)

As mentioned earlier, Tennessee's primary method of evaluating the rehabilitation process is counting the number of Status 26 (employed clients, homemakers, and unpaid family members) closures. Viaille (as quoted in Hills, 1972) summarized the inadequacy of using the present quota system of Status 26 closures as the only criterion for judging counselor competence.

1. It tends to emphasize numbers rather than the quality of services.
2. It may tend to emphasize relatively non-complex cases requiring little counselor time.
3. It may tend to encourage closing a client's case before it is ready to close, in order to meet a quota.
4. It may tend to encourage keeping a client on the caseload longer than should be, in order to assure meeting next year's quota. (p. 128)

Also, Patterson (as reported in Hills, 1972) cautioned against coercing clients into available employment for expediency. Clients may be placed in jobs other than those for which they were trained simply to enable counselors to reach their quotas. Also, part-time employment may be counted because the fiscal year is almost over and the client has been unable to obtain full-time employment. When clients cannot find employment, they may be closed as homemakers or unpaid family members without concern for their meeting those criteria.

Hills (1972) suggested using the quantity and quality of services as a basis for describing the benefits of the program. This could release the pressure on counselors for accepting just any placement and encourage counselors to provide appropriate services and placement to the more severely disabled individuals who may have the greater need for the program.

Counselor Bias

In examining counselor bias, it is not necessary to determine whether the stereotypical views counselors may hold regarding clients are negative. Instead, it is only necessary to determine if there are stereotypic views that influence counselor behavior and the outcome of the rehabilitation process. Before discussing the possible effects of stereotyping rehabilitation services clients, it is worthwhile to note Steger's (1981) comments that in general stereotypes are false, invalid or highly exaggerated generalizations made about a given group. Farley (as reported in Steger, 1981) listed nine stereotypical beliefs about women employees which are widely accepted.

1. A woman's place is in the home.
2. Women aren't seriously attached to the labor force, they work for pocket money.
3. Women are out ill more than male workers--they cost the company more.
4. Women don't work as long or as regularly as their male co-workers, their training is costly and largely wasted.
5. Married women take jobs away from men, in fact they ought to quit the jobs they hold now.
6. Women should stick to "women's jobs" and shouldn't compete for "men's jobs".
7. Women don't want responsibility on the job. They don't want promotions or job changes that add to their load.

8. The employment of mothers leads to juvenile delinquency.
9. Men don't like to work for women superiors. (pp. 11-12)

Additional stereotypical beliefs have been suggested. These include: "Women don't like to work for women supervisors" and "A woman's place is not in the home".

Malik (1973/1974) reported stereotypical rationalizations regarding nonwhites that increase racism through "deficit" theories: nonwhites are (a) constitutionally inferior, (b) victimized by accumulated environmental deficits, (c) inadequately socialized, and (d) incapsulated within autonomous cultures.

Wright (as reported in Steger, 1981) suggested physically disabled persons are a minority in the same sense as traditional minority groups with similar group stereotypes, role conflicts, and under-privileged social status position. Steger (1981) reported that,

There is often a sense of mystification about the disabled person who is seen as helpless mentally, physically, and morally, yet also as possessing special supernatural gifts, such as extrasensory perception, extraordinary patience and humility, or a mystical closeness to the essentials of life. (p.33)

Weinberg-Asher (as reported in Steger, 1981) stated the disabled are viewed as lacking in social interaction skills. "They are seen as less intelligent, less cheerful, less popular, less aggressive, less happy, less relaxing, less enjoyable to be with, less likeable and less physically attractive" (p. 33).

Halcomb (1984) stated that handicapped women are doubly discriminated against as a result of being both disabled and female since the stereotypes ascribed to both disabled people in general and

women consists of passivity, dependence, helplessness and failure. "They are the victims of a 'less than whole' attitude held by able-bodied women and men, as well as a 'sexist' attitude held, not only by able-bodied persons, but also by disabled men in their own subculture" (Holcomb, 1984, p. 18). For example, disabled women have been seen as unable to accept the responsibilities of being a wife and parent, incapable of earning a living, and generally unattractive.

Kapland (1984) also reported stereotypical views affecting handicapped women. They were perceived as less emotionally healthy (well-adjusted, assertive) than males by rehabilitation counseling students. Obese women, as compared to obese men, were perceived to be not only less physically attractive but less intelligent than obese men by these rehabilitation counseling students. Furthermore, stereotypical views affected potential plans for rehabilitation in that obese women were more often directed towards psychological counseling and homebound employment than were obese men.

In a Tennessee Valley Authority memorandum regarding attitudes regarding the disabled person, Fletcher (1986) noted the report of Gliedman and Roth that many people believe that disability is a result of parents' sins leading to God's punishment on their children. Thus, individuals are reluctant to become involved with the disabled. Furthermore, in addition to their fears regarding their own vulnerability when confronted with visibly handicapped individuals, most Americans perceive disability as failure. Handicapped individuals are usually placed into a "sick role" from which they generally are not permitted to leave. The handicapped

individual is expected to "subordinate his/her own interest and desires--which include leading a normal social life—to the therapeutic goals and programs decreed by the professional who is providing the help" (p. 2). Whereas the able-bodied person is able to return to normal role obligations, the handicapped person is considered incapable of leading a normal social life. The disabled person is then considered socially incompetent in every respect and considered powerless. Gliedman and Roth, as quoted by Fletcher (1986) stated,

The handicapped person is not merely defined as powerless because he is "sick". He is defined as doubly powerless because he cannot even master the role obligations of an "ill" able-bodied, individual of the same age. The able-bodied individual succeeds at getting well (but the handicapped person stays "sick").

Thus, to relate to a person through the lens of the handicapped role is to imply that the person has been reduced to a state of absolute social incapacity. A person incapable of discharging any social function is no longer a social creature; he is an isolate. Or, to recall the original Greek meaning of the word (handicapped), he is an "idiot". (p. 2)

Moreover, Atkins (1982) described some of the effects of maintaining stereotypical beliefs:

Similarly, the attitudes of majority America constitutes crucial blockages to advanced social-economic status for minority and disabled women. First, many Americans continue to believe that minority women are unmotivated and thereby unable to improve their status. Second some majority Americans lack understanding and respect for the struggles encountered by minority and disabled females. Third, disabled females often are believed to be incapable of leading productive lives and are relegated to a less than human or female position. Lastly, the result of these stereotypic attitudes is the denial of needed opportunities to numerous motivated disabled and minority women. (p. 40)

After reviewing the stereotypical beliefs regarding blacks, women, and disabled individuals in our society, there is concern that rehabilitation counselors' beliefs may influence the way they view their clients and the clients' potential for successful rehabilitation. Steger (1981) stated, "The attitudes which society has towards disabled persons are frequently more handicapping to the person than the disability" (p. 31).

Survey of Government Statistics and Recent Research

Although the number of research studies regarding the quality of rehabilitation services is limited, there are statistics available regarding the number of individuals in our society who are disabled, employed though disabled, considered successfully rehabilitated, etc. To gain perspective regarding the rehabilitation process, these statistics will be included in the discussion of recent literature about discrimination against individuals with handicaps and subgroups within this major category.

Bowe (1985) reported the latest Current Population Survey showing that of America's 36 million disabled citizens, 14 million are working age adults (16-64), 4 million are children, and 9 million are senior citizens. Thus, one in every 11 people in the age range from 16-64 is disabled. It is estimated that 9 million people have unreported disabilities, possibly due to reluctance to expose themselves to society's negative attitudes towards disability (Bowe, 1985). The Rehab Group (1979) reported that handicapped individuals are employed across all employment categories and across all income ranges. However,

Schroedel and Jacobsen (1978) reported that rehabilitants are more likely to be in low paying and less prestigious positions. They also noted that workers with disabilities are often in the secondary labor market, which is characterized by low wages, poor job security, and poor working conditions.

In examining the rehabilitation process for individuals with disabilities, it is important to understand how these individuals may differ from the general population. Therefore, the comparisons of non-disabled and disabled individuals will be made using the 1980 Census statistics reported in Bowe (1983). The "typical" working-age American is age 34, a high school graduate, married, in the labor force working full time and had about \$8000 in income from all sources in 1980. The "typical" working-age disabled American is male, age 50, a high school graduate, married, not in the labor force (full- or part-time) and had about \$5000 in income from all sources in 1980. Bowe (1985) reported that while the typical non-disabled person between the ages of 16 and 64 worked, only one-third of the disabled men and one-fifth of the disabled women had jobs. The Rehab Group (1979) listed the primary disability for both black and white men as trouble with back and spine and the second most common as cardiac condition. The primary disability listed for black and white women was arthritis or rheumatism. The second most frequent disability for white women was trouble with back or spine, while for black women cardiac was listed.

In reviewing data for rehabilitated disabled people nationwide (Table 1) by major types of disabilities and severity of disability classification, it is apparent that one should not assume that

TABLE 1
PERCENTAGES OF REHABILITATED CLIENTS
BY SEVERITY OF DISABILITY AND
TYPE OF DISABILITY

Type of Disability	Disabled	Severely Disabled
Mental illness	31.2	23.8
Orthopedic impairments	17.1	21.1
Mental retardation	8.3	17.1
Visual impairments	7.0	4.8
Digestive disorders	9.6	1.6
Hearing impairments	4.5	2.5
Blindness, both eyes		7.4
Genito-urinary	4.8	1.1
Absence of extremities	2.0	3.1
Heart disease	1.6	3.4
Deafness		4.9
Total population	155,143	124,242

Source: Disability and Consumer Power. (1979, March--April).
American Rehabilitation, 4(4).

any specific type of disability or severity of disability classification automatically prevents an individual from being rehabilitated.

The Rehab Group (1979) presented statistics regarding the number of disabled people working by type of disability. Thirty-five percent of the blind and visually impaired, 37% of the deaf and hearing impaired, 33% of the speech impaired, and 21% of those with paralysis were employed. In addition, 48% of those individuals with upper extremity orthopedic handicaps, 42% of those with lower extremity handicaps, and 30% of those with absence of one major extremity were employed. Thus, in spite of their disabling conditions, many people have been able to overcome or circumvent their disabilities sufficiently to be employed. These include those who may not have received rehabilitation services.

Although these statistics do not account for all types of disabilities, they do indicate that many disabled Americans are unwilling to be financially incapacitated by their disabilities and are working in spite of limitations. The realization that large numbers of people with disabilities can be economically productive in our society reinforces the goal of rehabilitation agencies in assisting clients to become employable.

In the 1978 Social Security Survey of Disability and Work (Bye and Schecter, 1982), approximately 127 million adults of working age (18-64) were asked if they considered themselves as having any work limitation as a result of health problems. Of these 21.9 million (17.2%) considered themselves as having a work limitation resulting from a health problem. Almost 11 million (8.6%) reported themselves as severely disabled (i.e., unable to work at all or

unable to work regularly). These statistics varied by race, gender, and age. Bowe (1983) reported statistics for disabled individuals showing that 37.3% of the white males, 18.8% of the black males, 20.5% of the white females, and 14.6% of the black females were employed. Bowe (1983) also provided the following breakdown of disabled individuals by age:

Persons age	16-24	---(3.3%)
	25-34	----- (5.0%)
	35-44	----- (7.1%)
	45-54	----- (12.3%)
	55-64	----- (24.1%)
	65-74	----- (29.7%)

Furthermore, Bowe (1983) presented 1982 Current Population Statistics for various occupations by gender and disability classification showing that women were generally employed in clerical and service areas regardless of disability classification. However, disabled women more often worked in service areas. Conversely, men were employed across all occupational categories.

Since the target population for this study consisted of those Tennesseans served by the Division of Rehabilitation Services, it is important to examine the total population of Tennessee, the income levels for Tennesseans, and the clients served by the agency. The 1980 Census for Tennessee provided information by race and gender for all citizens (Table 2).

In order to evaluate the financial benefits of rehabilitation services to disabled individuals, it is important to first note the general income range for Tennesseans in terms of gender and race since

TABLE 2
PERCENTAGES BY RACE AND GENDER FOR 1980
CENSUS OF POPULATION FOR THE
STATE OF TENNESSEE

Group	Number	Percent of Gender by Race	Percent of Total Population
Males			
White	1,862,465	84	
Black	339,168	15	
Other	14,967	1	
Total	2,216,600		48
Females			
White	1,972,987	83	
Black	386,774	16	
Other	14,759	1	
Total	2,374,520		52

Source: Tennessee Statistical Abstract for 1983/1984.

these overall statistics can be used to compare rehabilitated clients' incomes to those of the general population. In reviewing the income status of Tennesseans by gender and race (Table 3), it is apparent that almost two-thirds of the women earned less than \$10,000 a year while only a fourth of the males did so. It is also apparent that almost half of the black population earned less than \$10,000 a year while only a fourth of the white population did so.

For 1982 the Tennessee Rehabilitation Services population was classified by race and gender as indicated in Table 4. It appears that while there were more women in the state, more men applied for rehabilitation services. This reflects the overall Tennessee 1980 census population statistics showing more men were employed than women (1.2 million men as compared to 1.0 million women) and had more work disabilities (154,000 men as compared to 148,000 women).

The Tennessee Division of Rehabilitation Services maintains general statistical information on clients served by the agency. "Tennessee DRS Statistics FY 1982" reported that of the 27,918 individuals served that year, 4,795 were rehabilitated and of these, 2,147 were classified as severely disabled. These statistics for case service costs showed that 36% of the funds (\$4,763,618) were spent for restoration and 28% of the funds (\$3,744,577) were spent for training.

Thus, it is possible to conclude that many individuals with disabilities are able to participate in productive employment and are currently working. However, many are still waiting to become members of the labor force.

TABLE 3
INCOME RANGE AND MEDIAN INCOME
IN TENNESSEE BY GENDER
AND RACE, 1980

Income	Gender		Race	
	Male	Female	White	Black
Less than \$5,000	9.8	36.9	8.3	22.8
\$5,000 to \$7,499			7.5	12.3
\$7,500 to \$9,999			8.3	10.7
\$5,000 to \$9,999	15.3	27.2		
\$10,000 to \$14,999	17.3	16.4	17.5	17.3
\$15,000 to \$19,999	16.7	8.8	16.8	13.6
\$20,000 to \$24,999	14.1	4.7	14.3	9.2
\$25,000 to \$34,999	15.8	3.7	16.0	9.8
\$35,000 to \$49,999	7.3	1.4	7.4	3.2
\$50,000 and above	3.7	0.9	3.8	1.1
Median income	\$17,133	\$7,188	\$17,353	\$11,100

Source: "Women in the Labor Force, 1984" Tables 19 and 20

TABLE 4
TENNESSEE REHABILITATION
SERVICES POPULATION FOR
FISCAL YEAR 1982

Demographic Status	Total	Percent
Race		
Not known	105	.4
White	21,136	76.1
Black	6,471	23.3
American Indian or Alaskan	27	.1
Asian or Pacific	37	.1
Gender		
Not recorded	1	.0
Male	14,980	53.9
Female	12,795	46.1
Total	27,786	

Source: "Vocational Rehabilitation Data Base, File No. 1,
Program 123, 1983."

Rehabilitation agencies may need to evaluate how past services have been productive in reducing unemployment and determine additional ways to assist clients in reaching the goal of employment. This need is even more apparent in light of the higher rate of unemployment for individuals with disabilities. The "New Sources of Disability Status" (1984) provided general unemployment statistics by race and gender reflecting the increased number of unemployed disabled individuals as compared to non-disabled individuals. These labor statistics for March 1982 showed that (1) 15.9% white males with a work disability as compared to 9.1 with no work disability were unemployed, (2) 26.4% black males with a work disability as compared to 20.5 with no work disability were unemployed, (3) 16.8% white females with a work disability as compared to 7.7% with no work disability were unemployed, and (4) 26.6% black females with a work disability as compared to 17.0% with no work disability were unemployed.

Furthermore, in Vash's (1982) report, 47.8% of the unemployed disabled women had previous work histories which usually indicates a good chance for employment. Vash, (1982) also found that women more often had a decreased income of 50% or more as a result of their disability (82.8% of the women compared to 74.5% of the men). McNeil (1982) reported that work disabled men had average 1981 earnings of \$13,863 (men with no work disabilities averaged \$17,481) while work disabled women earned \$5,835 (women with no work disabilities averaged \$8,470).

Moreover, Vash (1982) explained that even among those individuals who had received rehabilitation services, there were sharp differences

in income according to gender. In the lowest weekly earnings category (\$100-\$124), 34% of the males and 48% of the females were represented. In the highest weekly earnings category (\$200 and over) 24% of the males and 10% of the females were represented. The "Rehab Brief" (January 1983) reported that rehabilitated women's weekly earnings are approximately 56% of that of rehabilitated men. Furthermore, Malik's (1973/1974) study found that disabled white and nonwhite women earn significantly less money than do disabled white and nonwhite men even when they are in similar occupational areas.

In general white males earned the highest income when groups of individuals in similar jobs were compared by race and gender. Steger (1981) provided information showing that women generally earn less than men. Ferraro (1984) offered an example of this in explaining that the job evaluator for the Government Printing Office awarded no points (points are related to job ratings and thereby pay rates) for female book binders "because the sewing was of the variety most women know how to perform, thereby undervaluing the female compared to the male bookbinder job" (p. 1170). Thus, females performing the same job as males received less pay.

Additional cause for concern for handicapped women can be seen in reduced benefits they receive through disability insurance, worker's compensation, etc., as well as their general level of poverty. Russo and Denmark (1984) stated that because many of the economic policies have been designed to meet the needs of working men, women have received fewer and less generous benefits from such programs as disability insurance because eligibility has been tied to

participation in the labor force and has been related to the amount of the person's earnings. This was reflected in such statistics as those provided by Social Security for insurance benefits awarded in 1983 showing that the 621,000 males averaged \$497 monthly while the 218,000 women averaged \$333 monthly ("Social Security Bulletin", 1983).

Pearch and McAdd (as reported in Ferraro, 1984) found that in spite of the phenomenal increase in women's participation in the labor force, women and children remained the fastest growing segment of our nation's poor simply because most women's wages were barely above the poverty level (currently the federal poverty level is at \$415 for a one-person household and \$850 for a family of four while minimum wage averages \$531 a month). Ferraro (1984) stated, "It is estimated that if women were paid the same wages that similarly qualified men earn, the number of families living in poverty would be cut in half" (p. 1161). Weiss (1985) reported the findings of the Southeast Women's Employment Coalition that the average wage gap between Southern white men (the highest paid workers in the South) and black women (the lowest paid) is \$9500. Weiss also reported that 75% of the Southern poor were members of female headed families. The proportion of poor families across the country headed by women reached 47% in 1981. This was broken down to show that 70% of poor black families were headed by women as compared to 50% of poor Hispanic families and 39% of poor white families. (Russo and Demark [1984] stated 41% of all black families were maintained by women compared to 23% of Hispanic families and 13% of white families.) Russo and Denmark also stated that the

two-parent family assumption is also less likely to apply to disabled women because they are likely to marry later and are more likely to become divorced. They also found that of those individuals who were separated, divorced, widowed, or married with a partner absent, more were disabled females than disabled males.

This is not to say that gender and race are the only factors related to poverty. However, it is important to acknowledge a potential relationship in order to comprehend the need for disabled women and disabled blacks to be given the opportunity for an improved income level as a result of rehabilitation services. It is also worthwhile to examine the poverty status for disabled individuals in general versus non-disabled individuals in general to further understand why disabled citizens need effective rehabilitation services. The Rehab Group (1979, pp. 17-18) provided data showing that 17.2% of the males and 16.5% of the females classified as living in poverty were prevented from working due to a work disability while only 4.3% of the males and 5.2% of the females not in poverty were prevented from working. Thus, it appears that more disabled individuals are classified as living in poverty. This is not to say disability necessarily causes poverty. Bowe (1985) suggested that disability is more prevalent among disadvantaged persons than among the rest of society due to lack of prenatal care, lack of adequate health care and/or high risk employment.

Having examined the possible interrelatedness of race, gender, disability, and poverty, it is worthwhile to consider the influence rehabilitation counselors may have on clients. According to the "Rehab Brief" (January 1983) describing five papers presented at the

Sixth Annual Mary E. Switzer Memorial Seminar, disabled women have been given inadequate counseling and denied opportunities for employment--even as rehabilitation counselors. Whereas Bolton (1981) and Hull (1979) reaffirmed that clients should be evaluated and served individually rather than stereotypically, Stegers (1981) reported that rehabilitation counselors often directed clients into gender stereotypic (i.e., conventional beliefs regarding people based on their being male or female rather than accepting them as individuals with characteristics unique to themselves) vocational objectives. Bem and Bem (as reported in Steger, 1981) listed ways in which counselors perpetuate the system which keeps women in jobs with low status and low pay.

1. Counselors maintain that women clients are free to choose whatever career they care to, but this claim overlooks the ways in which society controls not only women's alternatives, but their motivation to choose.
2. Counselors refer to the physiological differences between men and women. But these physical differences do not prevent women in other countries from working in a variety of jobs commonly thought to be too hard for women. The physiological argument also fails to take into consideration the wide biological differences between members of the same sex group.
3. Counselors point out that the role of homemaker is a needed and important role which precludes women from serious involvement in the labor market. This argument is usually coupled with the responsibility of the woman for child-rearing. However, the average woman lives to be age 74, therefore, from about the age of 33 when her children no longer require full care, the woman is forced into early retirement....
4. Counselors maintain the women have sufficient leisure time to become involved in outside activities which would allow women to express their unique personality. But this means that a woman's unique identity most often determines only the periphery of her life rather than the core. (pp. 13-14)

Counselors, as well as educators, families, and friends, still tell disabled women "Your family will take care of you" or "No one would hire you if you were able to get through the training requirements" (Carrick and Bibb, 1982, p.29). Since disabled women frequently are not expected to work, counselors see little reason to expend time, energy or money to rehabilitate female clients. Furthermore, disabled women are often told they have no right to consider marriage or children. They receive very little support to accept responsibility for themselves or others. They are denied opportunities for actualization and affirmation.

There is the additional denial of human rights. Galiber (as quoted in Atkins, 1982) stated, "Too many minority handicapped women are hungry, unclothed, unemployed, unsheltered, and completely unaware of the better life which is their right" (p. 44).

Some rehabilitation counselors encourage women clients not to go into competitive employment where they may be rejected but to remain in traditional employment, if they in fact encourage women clients to seek employment at all. If they have not offered alternatives, rehabilitation counselors may have failed in serving disabled female clients. Although this may be caused by concern that the client will be rejected by employers if they attempt non-traditional jobs, they are denying the client the right to fail. Atkins (1982) explained that no one has the right to deny a woman the right to fail. "If failure occurs, however, women must be willing to support and help their peers to refocus and proceed with other options" (p. 40).

Kriegsman and Celotta are noted in the "Rehab Brief" (1983) for their recommendations that women with disabilities receive training

in relationship building and problem solving strategies. These include learning to assert their human rights which may include the right "not to be patronized, to feel and express anger, to refuse requests (without feeling guilty), to make mistakes (and have a chance to correct them), and to have and express ideas and feelings, and to ask questions" (p. 3).

Vash (1982) stated that in America, the Calvinist protestant work ethic encourages people to choose life vocations that advance one's total mind-body-spirit development. When family, friends, educators, and counselors encourage disabled women to accept any job rather than matching skills and interests, they are denying self-actualization through not permitting women to choose "the path with heart" (p. 17) which would lead to a sense of encompassing purpose in one's life. Vash further related that role restrictions "create inner barriers of fear and ignorance along with outer barriers of discrimination and neglect" (1982, p. 16).

Atkins (1982) wrote that fear is the first obstacle to self-actualization. This may be fear of assertion to acquire rights or inability to see themselves in any role other than self-devaluated, dependent, and restricted. Disabled women have to deal with the negative aspect concerning their status as females and a minority as well as dealing with the realities of internal and external obstacles of physical and/or mental disabilities.

Russo and Denmark (1984) stated that although the problems of minority women, disabled women, young women, and aged women differ, all

women are directly or indirectly affected by sex-role stereotyping and sex discrimination in that the powerlessness, dependency, and poverty associated with women's roles and the devaluation of women's status are destructive to women's mental health. According to Vash (1982), sex role stereotyping is the second major work-related problem for disabled women (the other being the inability to meet specialized needs for toileting such as wide stalls or low sinks in restrooms). While rehabilitation engineers are capable of designing ways to meet the toileting needs, much remains to be done regarding the problem of sex-role stereotyping.

Vash (1982) explained that women have been excluded from prime jobs and directed into needed but undesirable work roles, leaving the better jobs for men. This may have occurred through sex role stereotyping which persuaded women and society at large that certain roles are "unnatural," "inappropriate" or "impossible" (p. 16). These roles have required higher risks and thereby higher rewards. Women have been rewarded for "passive, compliant, and dependent behavior" that results in jobs with lower salaries, lowered self-esteem, and little social recognition. Oppenheimer (as reported in Steger, 1981) documented that jobs which have been commonly sex-labeled as "female jobs" were those that depended on skilled but cheap labor, those where most of the training was acquired by the individual before employment, rather than on the job, and those where career continuity was not essential.

Women with disabilities already have their ranges of vocational options curtailed by the handicapping effects of their disabilities. The natural barrier is barrier

enough. When the artificial barrier of "occupational inappropriateness" is combined with it, the available options diminish quickly. (Vash, 1982, p.20)

Ferraro (1984) explained that even today the jobs into which women are usually directed have a lot in common in that they are often similar to work that is done in the home—housework, nursing, teaching, child care, organization, recordkeeping, and correspondence. When women do work outside the home their skills are undervalued when compared to jobs generally held by men but requiring similar skills. "The result is that dog pound attendants, mostly men, are paid more than child-care workers, mostly women, with whom we entrust responsibility for the future of our society" (Ferraro, 1984, p. 1168).

Another major area of discrimination exists in denying women access to physical labor.

What if her disability is intellectual and her best worker resource is her "brawn"? What if her disability is emotional and her best chances for success lie in outdoor, physical work requiring minimal interpersonal contacts? The chances are, these options will be ignored by guidance professionals who will, instead, try to prepare her to function in a clean, indoor, boring, factory assembly job entailing continuous (abrasive) contact with equally unfulfilled workers. (Vash, 1982, p. 20)

Vash (1982) described the "Bulova watch syndrome" in which rehabilitation counselors placed people in categories of jobs. For example, all disabled men whose walking ability was impaired, but whose manual finger dexterity was average or better were given watch repair as their vocational option, whether they wanted it or not. Similarly, women were directed to assume homemaking responsibilities, whether they wanted to do so or not.

Thurer (1982) further stated that when women with disabilities have been trained for employment, often they have been trained for less skilled jobs than men, and in general, have received fewer rehabilitation services than men have. Atkins and Wright (1980) reported that in spite of a greater need for more schooling, black clients have been less likely to receive training by the rehabilitation agency. Regarding college or university training, they noted that 11.2% of the white clients and only 5.14% of the black clients had received higher education with agency financial support. Even among the non-disabled, Killingsworth (as reported in Malik, 1973/1974) found unemployment rates for black men who attended college were higher than white men who did not finish grade school and higher among black male college graduates than among white male high school graduates.

Training appears to be an important factor of successful rehabilitation for many clients. However, according to Pitts (1980), Growick (1976), Mottola (1973), Flynn (1975) and Bowan and Micek (1973), clients sometimes have been closed in the same type of job after training that they held prior to rehabilitation services. These may have been appropriate closures but created the question as to the need for training.

Vash (1982) reported that while there have been isolated and sporadic efforts of rehabilitation counselors to help disabled women move into blue collar careers, the counselors' efforts to help motivated women enter male-dominated trades were often against supervisor resistance. Vash also related that gradually increasing

numbers of men are acknowledging willingness to remain at home to carry out duties while more work-oriented wives are earning the family living. However, this is not a new concept in rehabilitation circles. For decades male clients have been rehabilitated as homemakers freeing their wives to become wage earners. In spite of this trend, Thurer (1982) reported that for fiscal year 1976 only 4% of the men were closed as "unpaid family workers" or "homemakers" while 30% of the women clients were closed in these non-wage-earning capacities. (This wide difference in numbers for females versus males may not show up when taking an initial glance at rehabilitation records since females are sometimes closed as competitively employed [such as unpaid domestic help] but having no income.)

Tinsley and Gaughan (1975) found that rehabilitation services generally result in a shift from occupations classified in the Dictionary of Occupational Titles (see Appendix C for an explanation) as miscellaneous and farming, fishing, forestry (and related work) toward the professional-management and clerical-sales occupations. The "Rehab Brief" (January 1983) reported that of those individuals who were employed at the time of successful rehabilitation (Status 26) closures, only 12% of the rehabilitated women entered industrial occupations as contrasted to 46% of the men.

Malik (1973/1974) discovered that disabled white women and non-white women were heavily concentrated in clerical and service occupations but disabled white men were distributed throughout the range of occupational areas. Daniels (as reported in Steger, 1981) stated

skilled trades and many of the professions were closed to women while nursing, library science, and dental hygiene remained dominated by women. The "Tennessee Data for Affirmative Action Plan 1984" gave the following seventeen job areas in which females held 50% or more of the positions: Professional Specialty (52.1%), Health Assessment and Treating (82.9%), Teachers, Librarians and Counselors (71.1%), Teachers, Elementary and Secondary (77.7%), Technical, Sales and Administrative Support Occupations (62.5%), Health Technicians and Technologists (84.1%), Other Sales Occupations (65.8%), Cashiers (83.9%), Administrative Support Including Clerical (75.9%), Computer Equipment Operators (60.7%), Secretaries, Stenographers and Typists (98.6%), Financial Records Processing (88.7%), Service Occupations (60.3%), Private Household (96.6%), Service Except Protective and Household (64.7%), Food Service (71.3%), and Machine Operators and Tenders (52.4%). Weiss (1985) reported the findings of the Southeast Women's Employment Coalition that most Southern women remained in three main job groupings: low wage manufacturing, low wage services, and low wage office work.

The only jobs in which over 50% of the positions were held by blacks were in the area of private household service occupations in which 64.8% were black and 62.7% were black females. Malik (1973/1974) stated that non-whites have been kept in a non-competency grouping that makes them available when needed by the economy and yet set apart in certain types of low paying, hard and unpleasant jobs. "When labor is scarce, they are given the lower range of better jobs; when economic conditions worsen, whites move in to take over the jobs that have been

set aside as 'nonwhite' work" (p. 25). Malik (1973/1974) further stated that nonwhite clients have been coerced toward menial jobs, despite qualifications or potential for employment at higher levels. They have not been counseled in terms of their highest potential but in terms of opportunities traditionally available to nonwhites.

Kahl (1983) explained that overall three out of five female entrants to the job market took white collar jobs in 1980--1981 while one out of three males did so. However, Kahl explained that for men white-collar employment typically meant a professional, administrative, or scientific position; but for women white collar was often synonymous with clerical. Blumrosen (as reported in Malik, 1973/1974) reported similar findings. Ferraro (1984) translated this into "pink-collar" jobs that were dominated by women and underpaid. These included secretaries (99% female), clerks (86% female), librarians (82% female), registered nurses (98% female), and elementary school teachers (85% female).

Nearly half of all male entrants but little more than one-tenth of all female entrants to the labor market took blue-collar jobs in 1980-1981. Ferraro (1984) pointed out that in this blue-collar grouping, women again were more likely to be working in low-paying textile, laundry, and stitching jobs, whereas men found more lucrative work in mining, welding, and operating precision machines.

Furthermore, for service jobs in 1980-1981, a principal employer of young workers, the various service occupations (food, cleaning, health, protective and private household services) attracted nearly 30% of the male entrants and 40% of the female entrants age 16-19. For the age

group 25-54, relatively few men entered service occupations, but more than 1 million women did so. "Many adult women took jobs with minimal entry requirements such as waitress, bartender, building cleaner, private household worker, and nursing aide. These women appeared to augment the supply of young workers for low-pay, low-skill service jobs" (Kahl, 1983, p. 25).

Conclusion

In conclusion, stereotypical beliefs regarding individuals with disabilities, blacks, and females appear to have influenced opportunities for rehabilitation clients. Disabled individuals, particularly those who are black and/or female have had a higher probability of being below the poverty level. Pink-collar employment has often restricted women from improving their economic status. These problems have created a need to examine the contribution of rehabilitation services to enhance the status of disabled individuals, particularly if they are secondarily impaired by gender and/or race.

CHAPTER III

METHODS AND PROCEDURES

There were three primary objectives of this study. They are as follows:

1. To determine if there is discrimination against subgroups of Tennessee Rehabilitation Services clients (by gender, race, and/or severity of disability classification).
2. To determine if cost/benefit analyses (in terms of case expenditures and client salaries at closure) reveal adequate use of funds.
3. To ascertain Tennessee Division of Rehabilitation counselors' perception of service equity and effectiveness as well as recommendations for improving service delivery.

The investigator sought to determine if both counselor bias due to stereotyping clients and counselor-creaming bias due to the counselors' efforts to meet the quota for successful rehabilitation (Status 26) closures existed in the rehabilitation program.

Most of the information relevant to this study is public record. The investigator simply reviewed the client data in terms of client subgroups by race, gender, and severity of disability classification rather than simply looking at the grand total. At present the agency does not compare subgroups other than looking at overall case expenditures and salaries at closure for severely disabled versus non-severely disabled clients.

Types of Bias

Data was evaluated by two major types of discrimination: counselor creaming and counselor bias. The following areas were evaluated to determine if discrimination occurs and if the program is cost effective.

Counselor Creaming

Before considering the problem of counselor creaming, it is important to restate eligibility criteria. Also, note that clients can legitimately be closed as rehabilitated if they are enabled to be homemakers or unpaid family workers or placed in sheltered employment when these goals are appropriate.

It will be required to show that the following conditions exist for each individual determined eligible for Vocational Rehabilitation services.

- (1) The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment; and
- (2) A reasonable expectation that Vocational Rehabilitation services may benefit the individual in terms of employability. (VRPM 1505.03)

The manual criteria for status 26 closure as rehabilitated are as follows:

When an individual is determined to be rehabilitated, such individual must have been, as a minimum:

- (a) provided an evaluation of rehabilitation potential, and counseling and guidance as essential vocational rehabilitation services,
- (b) provided appropriate vocational rehabilitation services in accordance with the Individualized Written Rehabilitation Program, or amendments thereto, and
- (c) determined to have achieved a suitable employment objective which has been maintained for a period of not less than sixty days.

Therefore, raters were asked to rate counselor responses as biased if these guidelines were ignored or if clients were treated differently due to their gender, race or severity of disability classification. Counselors had previously been asked to respond to questionnaires regarding the influence of quotas for Status 26 closures on the rehabilitation process and resultant service effectiveness.

Counselors had also been asked to indicate whether Status 26 quotas affected the length, types, and appropriateness of services provided as well as adherence to manual guidelines including the Individualized Written Rehabilitation Program. They had also been asked to indicate whether clients goals and needs were ignored due to these quotas. Furthermore, they had been asked to indicate whether eligibility was based on expected costs of services rather than as clients' disability, functional limitations, and feasibility. Finally they had been asked to express their opinion as to whether or not Status 26 quotas reduce service effectiveness and to rate recommendations for improving the rehabilitation process.

Counselor Bias

Computer data and counselor questionnaires were used to evaluate the possible existence of counselor bias. Data were evaluated in terms of counselor expectations for clients and their treatment of clients due to the clients' gender, race, or severity of disability classification. Client groups were compared in the areas of the

numbers of applicants and rehabilitants, client expenditures, types of disabilities served, and work statuses at closure. Furthermore, client groups were compared by the number earning minimum wage, earning Substantial Gainful Activity (\$70.00 a week), weekly earnings, and whether or not they were above the poverty level at closure.

Initially data was requested to compare rehabilitants by their occupations at closure as well as the affect of disability on occupations and income at closure. Also, information was requested on the types and lengths of services provided to clients. However, central office staff explained that this information was unavailable due to the time and cost involved in developing a program to show the data by gender, race and severity of disability classification. Therefore, the only data for this area of the study were counselor reports.

Sample

There were two groups of subjects chosen for this study. These were Rehabilitation Services clients and counselors. The client sample consisted of those clients served by the Tennessee Division of Rehabilitation Services in Federal Fiscal Year 1985 (a total of 19,904 clients). The primary subsample consisted of those 3,946 clients closed in Fiscal Year 1985 as successfully rehabilitated (i.e., those individuals for whom services resulted in the client becoming employed or enabled to perform as an unpaid family member or homemaker).

The counselor population consisted of those counselors employed by the Department of Human Services and assigned to the Division of Rehabilitation Services in Fiscal Year 1985. There were approximately 137 counselor positions in the division at the time of the study. However, at the time the questionnaires were mailed to counselors, (July 1985), there were approximately 125 counselors employed, 15 of whom were new employees (one month or less).

Risks to clients were minimal since the clients in the sample were those clients whose cases were closed in Fiscal Year 1985 as successfully rehabilitated. Benefits to these specific clients were also minimal for the same reason. However, since they may reapply and receive services in the future, they may be recipients of improved service delivery as a result of the study.

Since counselors may have feared administrative reprisal for expressing their opinions, they were possibly at risk. However, anonymity was preserved by having counselors mail unsigned and unnumbered forms directly to the investigator's home. Thereby, their identity also remained hidden from the investigator, who is a co-worker. All information was reported by group responses.

Counselors could benefit from the study since it is conceivable that the information will be used to facilitate their work and improve their future service delivery. Also, it may possibly permit them to have input into administrative decisions.

Instrumentation

Input from counselors regarding their perception of the effectiveness of the program and equity to the clients was not a part of the Rehabilitation Services program at the time of the study. Therefore, a questionnaire was developed to obtain this information and recommendations for improving service delivery. The questionnaire was given to three counselors to examine and to suggest changes prior to implementation. (See Appendix F for a copy of the questionnaire and cover letter.)

Since there was only a limited amount of client data for types of services received, incomes at closure, case expenditures, etc., Rehabilitation Services' central office staff offered to develop a program to pull the necessary data from the computer files. Central office staff was able to supply most of the requested information. However, the data provided by central office staff were not individualized per client but were group frequencies, totals, or averages. Since distribution of the population was not known and nominal measures were used, the basic assumptions of parametric tests could not be met. Since the data provided by central office staff were discrete variables (frequency counts for clients by gender, race, and severity of disability classification for types of disabilities and work statuses), the chi square test was used for these topics. Since the data for expenditures were totals per demographic group and data for incomes were averages per demographic group, no statistical testing was possible for these topics.

Data Collection

Questionnaires were sent to all rehabilitation counselors employed by the Tennessee Division of Rehabilitation Services in July 1985. They were asked to rate the frequency of counselor behaviors and to provide ratings of suggestions to improve the rehabilitation process. They were also asked to rate the effectiveness of the system. Counselors were asked to return the unsigned questionnaires directly to the investigator's home.

The computer printouts furnished the following information by subgroups (non-severely disabled and severely disabled black females, non-severely disabled and severely disabled white females, non-severely disabled and severely disabled black males and non-severely and severely disabled white males): populations at application and Status 26 closure, the different types of disabilities served, the average income at application and closure, the work statuses of clients closed in Status 26, and total expenditures. Furthermore, the number of SSI and SSDI cases entering the system, those SSDI/SSI recipients rehabilitated and the number closed as earning SGA (\$300 [\$610 for those who are blind]) and those individuals earning minimum wage (\$134 a week) were obtained from the computer reporting system R-300 (see Appendix G). Unfortunately, the central office staff was unable to provide data on specific occupations, types of services provided, and comparisons of services and income by types of disability due to the cost and time involved. However, enough data were obtained to provide a

comprehensive look at the successful rehabilitation (status 26) closures in Fiscal Year 1985.

Efforts to Reduce Researcher Bias

Since the researcher wanted to reduce the possibility of personal bias influencing the outcome of the study, four independent raters were selected to review the questionnaires for counselor bias. The individuals who were chosen were familiar with the system but outside the system. The results of the counselor questionnaires were given to the four independent reviewers: a social worker who is a vendor for Rehabilitation Services, a counselor in a local rehabilitation facility, a retired federal employee, and a vocational instructor. After having been told the policy guidelines for determining eligibility and a successful rehabilitation, they were instructed to read the questions and the percentages of responses to each question. They were then asked to state whether responses reflected bias for that question. The researcher did not share expected findings with them. Instead, they were allowed to determine for themselves what was considered bias and what percentages indicated bias. However, all reported to the investigator that they considered any violation of policy bias.

Furthermore, in order to reduce the possibility of bias in reporting the computer data, statistical tests were done whenever possible using the null hypothesis that there would be no differences between client groups. Moreover, the sample size of 19,904 clients was sufficiently large to reduce the risk.

CHAPTER IV

RESULTS

The information obtained from the counselor questionnaires and from the data collected by the program's central office is presented below. The results of the seventy-six (representing 69% of the experienced counselors employed by the agency at that time) returned counselor questionnaires were given to four independent reviewers. The reviewers examined the questions and the ratings (responses to each question were by the categories of never, rarely, sometimes, often, and always. The reviewers were asked to decide whether the responses indicated bias or no bias on the part of Tennessee's Rehabilitation Services counselors.

Clients were compared by gender, race, and severity of disability classification for the categories of application versus closure, types of disabilities served, client expenditures, and work statuses at closure. Their incomes were compared by groups and in terms of being above the poverty level, minimum wages, and earning Substantial Gainful Activity (\$70 a week).

Before examining the questionnaire data or comparing data for client groups, general information regarding Rehabilitation Services clients in FY 1985 will be presented.

Applicants, Open Cases, Rehabilitants

1. There were 19,904 clients during FY 1985 in this study. Of these 10,818 or 54% were applicants. Furthermore, 3,946 or 20% of

the total number of clients were closed as successfully rehabilitated.

2. The sample (all open cases in FY 1985) was 54% male, 79% white and 50% classified as non-severely disabled.

3. Of those applying for services during this period, 53% were male, 77% were white and 69% were classified as non-severely disabled.

4. Of those clients closed as successfully rehabilitated (Status 26) during this period, 52% were male, 82% were white, and 56% were classified as non-severely disabled.

Comparison of Incomes for Applicants to Rehabilitants

In FY 1985 the total income reported for all 10,818 applicants was \$11,234,652. The total income reported for all 3,946 rehabilitants in FY 1985 was \$30,583,592. Thus, while there were 2.7 times as many applicants as rehabilitants, the rehabilitants' annual total income was 2.7 times as great as the applicants. Furthermore, the average rehabilitant had an income 7.5 times as much as the average applicant. Thus, it appears that Tennessee's Rehabilitation Services program contributed to Tennessee's economy by increasing clients' incomes and thereby increasing taxes paid into the state's treasury and offsetting the cost of rehabilitation. (The total expenditures for the rehabilitants was \$9,847,654.53).

Questionnaire Data

The responses to the questionnaires were divided into two main categories of bias, counselor creaming (serving only those

clients who were quickly and easily rehabilitated) and counselor bias. (The actual percentages for counselor and rater responses are presented in Appendix H.)

Counselor Creaming

Bias from counselor creaming was found by the independent reviewers. All four raters agreed that bias existed due to counselor responses in the following areas: It is better utilization of time and funds to serve short-term clients than clients with multiple service needs (question 1). Due to the quota for Status 26 closures occupational goals on the IWRP are changed after services are provided (question 3), clients are more likely to be placed in a few main job categories (question 13), more short-term services are provided than long-term services (question 15), and "creative writing" may be necessary (question 28). Reaching quotas for Status 26 closures is more important than meeting the individual needs of each client (question 4), providing all appropriate services (question 5), or making sure clients are appropriately employed in their chosen occupation (question 6).

Three out of four raters agreed that bias existed due to counselor ratings in the following areas: Due to quotas for Status 26 closures, clients are placed in a few main training areas (question 2), unemployed clients are closed as unpaid domestic help, unpaid family workers, homemakers, etc., when jobs cannot be found for them (question 14), and ineligible clients are

served if they can be quickly closed in Status 26 (question 25). It is better utilization of public funds to serve many short-term clients than reduce SSI/SSDI roles (question 9), short term physical restoration services are the most appropriate use of funds (question 21), and more effective services would be provided if counselors did not have to worry about quotas (question 26). (Counselor responses for question 9 might be different if provided now due to the implementation of the Order of Selection as described in Appendix I.)

The overall rater consensus was that there was bias due to counselor creaming in the rehabilitation process in the Tennessee Division of Rehabilitation Services. From examining counselor responses and reviewer ratings of the questionnaires, the investigator concluded that there was counselor creaming when the length of services, the types of services, the accomplishment of Individualized Written Rehabilitation Program goals, the reasons for Status 26 closures, the cost of services, and adherence to manual guidelines were considered.

Counselor Bias

Three out of four raters agreed that there was bias due to counselor responses that clients already receiving SSI/SSDI are less motivated to become rehabilitated than other clients are (question 17) and that many severely disabled clients can be more effectively rehabilitated by being trained to work at home (question 23).

The independent reviewers were asked their overall opinion of the responses to the questionnaire. While all four stated they thought there was counselor creaming, all four of them stated they were not sure there was counselor bias indicated by counselor responses to the questionnaire.

Computer Data on Rehabilitation Services Clients

The information from central office is presented by categories of applicants, open cases, rehabilitants, work statuses, income, SSI/SSDI recipients, disabilities, and total expenditures.

The demographics of applicants to total open cases to closures as rehabilitants were compared. It is important to note that not all applicants were eligible for the Rehabilitation Services program since they may not have been certified as eligible due to not having a diagnosed disability, functional limitations, etc.

Applicants and Rehabilitants

Clients were compared by percentages (Table 5) as applicants, total cases, and closures in FY 1985.

TABLE 5

APPLICANTS, TOTAL OPEN CASES AND CLOSURES BY PERCENT

	Applicants	Total Cases	Closures
Male	53%	54%	52%
White	77%	79%	82%
Severely Disabled	31%	50%	44%

The investigator expected to find a similar percentage of clients by gender and race throughout the program. However, there appeared to be a difference in the percentages of black applicants and black rehabilitants. Since there was a 5% decrease from the number of black clients entering the system as applicants to those leaving the system as rehabilitated, the chi square test (χ^2) was done (Table 6). The number of rehabilitants in FY 1985 by race were the observed frequencies (fo). The percentages of clients at application by race multiplied by the total number of rehabilitants were used as the expected frequencies (fe). This was done because equal numbers of clients per groups could not be established prior to the study since actual Rehabilitation Services clients were used for this study.

TABLE 6
COMPARISON OF APPLICANTS TO REHABILITANTS

	Black	White
fe	907.58	3,038.42
fo	710	3,236

$\chi^2 = 55.85$ χ^2 rejection values for 1DF: p.05 = 3.84

Results: Since the calculated chi square of 55.85 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusions:

1. There was a higher rate of black clients entering the system at application when compared to those leaving the system as

rehabilitants. Thus, it appears white clients are more likely to be closed as successfully rehabilitated than black clients are.

2. There does not seem to be an appreciable difference in the percent of male applicants and male rehabilitants.

3. Although there were 52% male and 48% female rehabilitants as compared to 53% male and 47% applicants, the results are not practically meaningful.

4. In comparing non-severely disabled and severely disabled clients, the results are confounded by the number of applicants who may or may not have been accepted as clients.

Work Statuses of Rehabilitants

The six work statuses were examined (Table 7) and then divided into two major categories. These two categories of paid and unpaid employment were then compared.

In examining unpaid work versus paid work statuses, the clients in paid work statuses were 55% male, 82% white, and 57% classified as non severely disabled. For unpaid work statuses 91% were female, 80% were white and 44% were classified as non-severely disabled. Thus, percentages of clients in paid work statuses resembled the percentages for all rehabilitants.

However, females in unpaid work statuses represented twice the number of females in paid work statuses. Furthermore, there were 19% more severely disabled clients in unpaid work statuses.

Clients in unpaid work statuses made up the following percentages of the total population: 13% black female, 14%

TABLE 7

WORK STATUSES FOR REHABILITANTS IN FY 1985 BY GENDER, RACE
AND SEVERITY OF DISABILITY CLASSIFICATION (SEVERELY
DISABLED [SD] AND NON-SEVERELY DISABLED [NSD])

	Female		Male		Total
	Black	White	Black	White	
	<u>Paid</u>				
Competitive					
NSD	173	786	178	819	1956
SD	116	452	139	694	1401
Sheltered					
NSD	3	2	4	1	10
SD	7	28	16	33	84
Self Employed					
NSD	2	40	5	66	113
SD	2	27	5	49	83
Business					
Enterprise					
NSD	0	1	1	0	2
SD	0	2	1	2	5
	<u>Unpaid</u>				
Homemaker					
NSD	14	96	1	1	112
SD	30	100	7	9	146
Unpaid Family					
Member					
NSD	1	14	0	1	16
SD	1	9	4	4	18
Total	349	1,557	361	1,679	3,946

white female, 3% black male, <1% white male, 6% non-severely disabled, and 10% severely disabled clients. There was a difference in clients closed in unpaid work statuses in that clients in this category were primarily female and severely disabled. Therefore, the chi square test was performed for unpaid work statuses by demographic groups.

The first comparison was done by gender (Table 8). (Since there were not equal numbers of clients in each group in this study, the percentages by gender for Status 26 were used as the expected frequencies.)

Result: Since the calculated chi square of 213.83 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference by gender for clients in unpaid work statuses. Since 91% of the clients closed in unpaid work categories were female, females were more likely to be closed in unpaid work statuses than men were.

Clients in unpaid work statuses were also compared by race. The results of this comparison are presented in Table 9.

Result: Since the calculated chi square of .68 does not exceed 3.84, the null hypothesis may not be rejected.

Conclusion: There was not a significant difference in clients closed in unpaid work statuses by race.

Clients closed in unpaid work statuses were, also, compared by their severity of disability classification. The results of the comparison are shown in Table 10.

TABLE 8
UNPAID WORK STATUSES BY GENDER

	Female	Male
fe*	140.16	151.84
fo	265	27

*Using the percentages of total Status 26 closures by gender as the expected frequencies.

$\chi^2 = 213.83$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

TABLE 9
UNPAID WORK STATUSES BY RACE

	Black	White
fe*	52.56	239.44
fo	58	234

*Using the percentages of total Status 26 closures by race as the expected frequencies.

$\chi^2 = .68$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

TABLE 10

UNPAID WORK STATUSES BY SEVERITY OF DISABILITY CLASSIFICATION
(SEVERELY DISABLED [SD] AND NON-SEVERELY DISABLED [NSD])

	NSD	SD
fe*	163.52	128.48
fo	128	164

*Using the percentages of total Status 26 closures by severity of disability classification as the expected frequencies.

$\chi^2 = 17.52$ χ^2 rejection values for 1DF: $p.05 = 3.84$

Result: Since the calculated chi square of 17.52 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference by severity of disability classification for clients closed in unpaid work statuses. Since 56% of the clients in unpaid work statuses were classified as severely disabled as compared to being 44% of the rehabilitants, it appears clients classified as severely disabled were more likely to be closed in unpaid categories than would represent their portion of the population.

The percentages by gender in unpaid work statuses (91%) can be compared to the findings of the Rehab Group (Table A-1, 1979) regarding the percent of disabled females choosing to be housewives rather than working outside the home after the onset of disability: overall total (27.9%) and occupational (40.7%). Furthermore, severely disabled female Rehabilitation Services clients made up 48% of the unpaid work statuses as compared to the 16.7% severely disabled females reported by the Rehab Group (Table A-1, 1979). Moreover, when comparing non-severely disabled to severely disabled clients, Tennessee Rehabilitation Services' severely disabled clients were 56% of the unpaid work statuses in FY 1985 as compared to the 10.3% severely disabled (males and females) choosing to be "housewives" as reported by the Rehab Group (Table A-1, 1979).

Income

Clients' incomes at application and closure were examined to determine if there was a difference by gender, race, and severity of disability classification. These comparisons were made of the average incomes, total annual incomes, percentages of the total annualized income, and average monthly incomes by demographic group. Comparisons were also made for rehabilitants in paid employment. Furthermore, clients were compared using the agency's stated average income for FY 1985.

Applicants

The average income per applicant in FY 1985 was \$1038.51. The total income for all applicants in FY 1985 was \$11,234,652 with the following breakdown by gender (\$6,076,148 for female clients and \$5,158,504 for male clients), by race (\$2,187,588 for black clients and \$9,047,064 for white clients), and by severity of disability classification (\$8,970,520 for NSD clients and \$2,264,132 for SD clients).

At application female clients had 54%, white clients had 81%, and non-severely disabled clients had 80% of the total income. At application black males had less income than women and white males. Also, severely-disabled clients had less income than non-severely disabled clients.

To determine if clients had incomes above the poverty level (\$415) or above minimum wage (\$581), monthly incomes were

examined as shown in Table 11. All client groups had incomes below the poverty level and minimum wage at application.

TABLE 11
AVERAGE MONTHLY INCOMES AT APPLICATION

	Female		Male	
	Black	White	Black	White
NSD*	129.00	111.80	51.60	94.60
SD	38.70	60.20	38.70	60.20

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

Rehabilitants

The average income per rehabilitant in FY 1985 was \$7750.53. The total income for rehabilitants in FY 1985 was \$30,583,592 with the following breakdown by gender (\$12,274,288 for female clients and \$18,309,304 for male clients), by race (\$4,815,096 for black clients and \$25,768,496 for white clients) and severity of disability classification (\$17,459,728 for NSD clients and \$13,123,864 for SD clients).

In examining the percentages of the total income by client group, women had a larger portion of the total income at application in FY 1985 while men had a larger portion at closure. Furthermore, black clients had a smaller portion of the total income at closure.

Also noteworthy, severely disabled clients had a much greater share of the income at closure.

All rehabilitants average monthly incomes were compared to the poverty level (\$415 a month) and minimum wage (\$581 a month) as shown in Table 12. It appears that all client groups at Status 26 averaged incomes above the poverty level at closure if one person household is used as the criterion. (One person household was the typical household size in fiscal year 1984.) However, it appears that only white males and non-severely disabled black males averaged incomes above minimum wage at closure when all clients closed as successfully rehabilitated were compared.

TABLE 12
AVERAGE MONTHLY INCOMES AT CLOSURE FOR
ALL REHABILITANTS IN FY 1985

	Female		Male	
	Black	White	Black	White
NSD*	533.20	541.80	645.00	799.80
SD	490.20	528.90	563.30	739.60

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

The previous comparisons were made for all applicants and all rehabilitants. There was concern that an accurate picture was unavailable for examining the contribution of rehabilitants in paid work statuses at Status 26 closure. Therefore, the

average monthly incomes of rehabilitants in paid employment statuses were compared to the poverty level (\$415 a month) and minimum wage (\$581 a month). The results are shown in Table 13. It appears that all client groups in paid work statuses at Status 26 closure averaged incomes above the poverty level and minimum wage. Also, noteworthy, severely disabled females closed in paid work statuses earned more than non-severely disabled females. Conversely, severely disabled males closed in paid work statuses earned less than non-severely disabled males.

TABLE 13

AVERAGE MONTHLY INCOMES AT CLOSURE FOR REHABILITANTS IN PAID
EMPLOYMENT IN FY 1985 BY GENDER, RACE AND SEVERITY OF
DISABILITY CLASSIFICATION (SEVERELY DISABLED [SD]
AND NON-SEVERELY DISABLED [NSD])

	Female		Male	
	Black	White	Black	White
NSD	582.61	618.45	653.46	807.82
SD	616.51	647.14	606.45	757.79

Furthermore, when incomes for rehabilitants in paid work statuses were compared to those for all rehabilitants, women, particularly those classified as severely disabled, had a higher average income (\$49 a month increase for non-severely disabled black women, \$67 for non-severely disabled white females,

\$119 for severely disabled white females and \$126 for severely disabled black females) whereas males averaged less than \$45 a month increases across all groups.

Rehabilitants' average incomes were compared at closure. Table 14 shows the percentages of average weekly income (using the state average of \$148.69 [M.I.S. 2, Report A]) for rehabilitants by gender, race, and severity of disability classification. Only white males and non-severely disabled black males earned 100% of the average weekly income at closure. However, when the average income for female clients was compared to the average income for male clients at closure, Rehabilitation Services female clients in FY 1985 averaged 72% of the income for male clients. This compares favorably to the 42% reported by McNeil (1981) and to the 56% reported in the Rehab Brief (1983).

TABLE 14

PERCENTAGES OF AVERAGE INCOME FOR REHABILITANTS BY GENDER, RACE
AND SEVERITY OF DISABILITY CLASSIFICATION (SEVERELY
DISABLED [SD] AND NON-SEVERELY DISABLED [NSD])

	Female		Male	
	Black	White	Black	White
NSD	83%	85%	101%	125%
SD	77%	83%	88%	116%

In spite of the financial improvements resulting from the Rehabilitation process, rehabilitants did not average the median income for Tennesseans for 1980 as stated in "Women in the Labor Force" (1984). These figures were \$7,188 for females in Tennessee as compared to \$6,440 for female clients, \$17,133 for males in Tennessee as compared to \$8,975 for male clients, \$11,100 for black individuals as compared to \$6,782 for black clients, and \$17,353 for white individuals as compared to \$7,963 for white clients. These differences may occur due to the fact that many clients were entering the work force late and did not have the opportunity to earn a commensurate income. Moreover, when black clients were compared to black Tennesseans in general, black rehabilitants earned 85% of the income white rehabilitants earned while black Tennesseans earned 64% of the income white Tennesseans earned. Similarly, female rehabilitants earned 72% of the income earned by male rehabilitants while female Tennesseans in general earned 42% of the income of male Tennesseans.

Furthermore, Tennessee Rehabilitation Services rehabilitants' incomes were compared to incomes for other disabled individuals as reported by McNeil (1982). While female clients in Tennessee earned more than the \$5,835 reported for disabled females by McNeil, male clients earned less than the \$13,863 reported for disabled males.

Minimum Wage

The percentages of all clients closed as successfully rehabilitated (Status 26) earning minimum wage are as follows: 56% of all female, 36% of all male, 57% of all black, 45% of all white, 45% of all non-severely disabled, and 49% of all severely disabled rehabilitants. Overall, 47% of the clients closed as successfully rehabilitated earned minimum wage at closure. The percentages of all rehabilitants competitively employed earning minimum wage are as follows: 68% of all female, 37% of all male, 62% of all black, 48% of all white, 48% of the non-severely disabled, and 54% of the severely disabled rehabilitants.

Clients closed as successfully rehabilitated earning minimum wage were compared (Table 15) by gender, race and severity of disability classification.

TABLE 15
REHABILITANTS EARNING MINIMUM WAGE

	Female		Male		Total
	Black	White	Black	White	
NSD*	116	543	88	260	1,007
SD	98	358	101	293	850
Total	214	901	189	553	1,857

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

Rehabilitants closed as successfully earning minimum wage (fo) were compared by gender (Table 16). The expected frequencies (fe) were obtained by using the percentages of clients in paid work statuses. Result: Since the calculated chi square of 169.78 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in males and females earning minimum wage at Status 26 closure in that 60% of all clients earning minimum wage were female.

Moreover, this result can be compared to the finding that female clients were 45% of the total of paid rehabilitants and 48% of the total Status 26 closures. It appears that women in a paid work status had an increased rate in being closed as earning minimum wage. Also, while more males were closed as rehabilitants, fewer actually earned minimum wage.

Rehabilitants earning minimum wage were compared by race (Table 17).

Result: Since the calculated chi square of 17.23 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in white and black clients earning minimum wage at Status 26 closure.

However, there was an increase in black clients earning minimum wage in that 22% of the clients in this category were black. This result can be compared to the finding that black clients were 18% of the total Status 26 closures and 18% of the paid

TABLE 16

REHABILITANTS EARNING MINIMUM WAGE BY GENDER

	Female	Male
fe*	835.65	1,021.35
fo	1,115	742

*Using the percentages of clients closed in paid work statuses by gender as the expected frequencies.

$\chi^2 = 169.78$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

TABLE 17

REHABILITANTS EARNING MINIMUM WAGE BY RACE

	Black	White
fe*	334.26	1,522.74
fo	403	1,454

*Using the percentages of clients closed in paid work statuses by race as the expected frequencies.

$\chi^2 = 17.23$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

rehabilitants. Thus, black clients in a paid work status had an increased rate in being closed as earning minimum wage.

Rehabilitants were then compared by severity of disability classification as shown in Table 18.

Result: Since the calculated chi square of 5.82 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in clients classified as non-severely disabled and severely disabled earning minimum wage at Status 26 closure.

TABLE 18
REHABILITANTS EARNING MINIMUM WAGE BY SEVERITY
OF DISABILITY CLASSIFICATION

	NSD	SD
fe*	1,058.49	798.51
fo	1,007	850

*Using the percentages of clients closed in paid work statuses by severity of disability classification as the expected frequencies.

$\chi^2 = 5.82$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

However, severely disabled clients in paid work statuses had an increased rate of being closed as earning minimum wage in that they represent 46% of the clients earning minimum wage. This result can be compared to the finding that they represent 43% of the clients in paid work statuses and 44% of the total Status 26 closures.

SSDI/SSI Recipients as Rehabilitation Services Clients

Table 19 shows the number of SS/SSDI recipients who applied for rehabilitation services, who were closed as successfully rehabilitated, and who were listed as earning Substantial Gainful Employment (\$70 a week). Of the 1,216 Rehabilitation Services clients receiving SSI or SSDI while in the application stage (Status 02) during FY 1985, 69% were white, 58% were male, and 67% were SSI recipients while 33% were SSDI recipients. Of the 263 SSI/SSDI recipients closed in Status 26 as successfully rehabilitated, 57% were male and 74% were white. Of the 130 clients earning SGA at closures (Status 26) 29% were male and 72% were white. However, these figures are misleading unless one also examines the results by specific demographic groups. The investigator found that 71% of the clients earning SGA were black female, 72% were white female, 41% were black male, and 29% were white male SSI/SSDI recipients.

A comparison (Table 20) was made of the rates of rehabilitants receiving SSI/SSDI by using the percent of applicants receiving SSI/SSDI as the expected frequencies.

Result: Since the calculated chi square of 3.84 does not exceed 7.81, the null hypothesis may not be rejected.

Conclusion: There was no significant difference in the rates of SSI/SSDI recipients closed as successfully rehabilitated.

Comparisons were made of the rates of clients receiving SSDI/ SSI closed as successfully rehabilitated clients earning SGA (\$300 a month) and those SSI/SSDI recipients closed as successfully rehabilitated.

TABLE 19

SSDI/SSI RECIPIENTS AS APPLICANTS FOR REHABILITATION
SERVICES, SUCCESSFUL REHABILITANTS AND SGA
(\$300 A MONTH) EARNERS IN FY 1985

	Female		Male	
	Black	White	Black	White
Status 02	160	346	221	489
Status 26	28	85	41	109
Earning SGA	20	61	17	32

TABLE 20

SSDI/SSI RECIPIENTS CLOSED AS REHABILITATION
SERVICES REHABILITANTS

	Black Females	White Females	Black Males	White Males
fe*	34.19	73.64	47.34	105.2
fo	28	85	41	109

*Using the percentages of applicants receiving SSDI/SDI as the expected frequencies.

$\chi^2 = 3.84$ χ^2 rejection values for 3DF: $p.05 = 7.81$

First, these clients were compared by gender (Table 21).

Result: Since the calculated chi square of 19.77 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

TABLE 21

SSDI/SSI RECIPIENTS EARNING SGA (\$300 A MONTH) BY GENDER

	Female	Male
fe*	55.9	74.1
fo	81	49

*Using the percentages of Rehabilitation Services clients receiving SSDI/SSI closed as successfully rehabilitated as the expected frequencies.

$\chi^2 = 19.77$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Conclusion: "There was a difference by gender between clients receiving Substantial Gainful Activity. Since 42% of the total SSDI/SSI rehabilitants were female while 62% of the SSDI/SSI clients earning Substantial Gainful Activity were female, it appears females were more likely to earn Substantial Gainful Activity. Since 57% of the total SSDI/SSI rehabilitants were male while 29% of the SSDI/SSI clients earning SGA were male, it appears males were less likely to earn Substantial Gainful Activity.

SSDI/SSI clients earning SGA of \$300 a month (Table 22) were also compared by race.

Result: Since the calculated chi square of .4 does not exceed 3.84, the null hypothesis may not be rejected.

TABLE 22

SSDI/SSI RECIPIENTS EARNING SGA (\$300 A MONTH) BY RACE

	Black	White
fe*	33.8	96.2
fo	37	93

*Using the percentages of Rehabilitation Services clients receiving SSDI/SSI closed as successfully rehabilitated as the expected frequencies.

$\chi^2 = .4$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Conclusion: There was not a difference in SSDI/SSI recipients earning SGA when clients were compared by race.

Disability Categories for Rehabilitation Services Recipients

Clients' disabilities were arbitrarily divided into seventeen categories combining many of the minor subgroups under these major headings.

The Division of Rehabilitation Services uses a similar breakdown in describing disability categories. These major categories are presented (Table 23) by total number of people per category and the percent of total clients.

There were only four categories of disabilities in which any grouping by gender, race, and severity of disability category was greater than 1% of the total sample. Those are described by totals and percentages.

Orthopedic Deformity or Functional Impairments Except Amputations

These include cerebral palsy, muscular dystrophy, arthritis, rheumatism, poliomyelitis, multiple sclerosis, Parkinson's disease and other impairments such as accidents and injuries. Clients in this disability category were compared by gender, race, and severity of disability classification (Table 24). Clients in the orthopedic category were compared by gender using the chi square test (Table 25).

Result: Since the calculated chi square of 108.76 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

TABLE 23

MAJOR DISABILITY CATEGORIES IN FY 1985
(BY TOTALS FOR EACH CATEGORY AND BY PERCENT OF THE
TOTAL NUMBER OF CLIENTS SERVED)

Disability	Total in Category	Percent of Clients
Visual		
Impaired	1,222	6
Blind	650	3
Hearing		
Impaired	507	3
Deaf	529	3
Orthopedic or Functional	5,143	26
Absence or Amputation	408	2
Mental, Psychoneurotic &		
Personality	6541	33
Tumor Caused	341	2
Allergic, Endocrine,		
Metabolic or Nutrition	688	3
Blood Disorders	97	<1
Nervous System	703	4
Cardiac & Circulatory	745	4
Respiratory	150	<1
Digestive	660	3
Genito-urinary	975	5
Speech	136	<1
Other Disabling Conditions	409	2

TABLE 24
ORTHOPEDIC CLIENTS IN FY 1985

	Female		Male		Total
	Black	White	Black	White	
NSD*	173	880	210	1,357	2,620
SD	185	755	255	1,328	2,523
Total	358	1,635	465	2,685	5,143

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

TABLE 25
ORTHOPEDIC BY GENDER

	Females	Males
fe*	2,365.78	2,777.22
fo	1,993	3,150

*Using the percentages of all Rehabilitation Services clients by gender as the expected frequencies.

$\chi^2 = 108.76$ χ^2 rejection values for 1DF: $p.05 = 3.84$

Conclusion: There was a difference in orthopedic clients by gender when compared by the percentages for all Rehabilitation Services clients in FY 1985. There were more male (61%) than female (39%) clients having an orthopedic disability. This can be compared to the finding that males represent only 56% of the client population. Furthermore, this finding can be compared to the national percentages (51% male) as reported by Smith and Gabe (Table I.A.1., 1984).

Clients in the orthopedic category were also compared by race using the chi square test (Table 26).

Result: Since the calculated chi square of 77.42 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in orthopedic clients by race when compared by the percentages of all Rehabilitation Services clients in FY 1985. Black clients comprised only 16% of this disability category as compared to being 21% of the total population.

Clients in the orthopedic disability category were also compared by severity of disability classification (Table 27).

Result: Since the calculated chi square of 1.82 does not exceed 3.84, the null hypothesis may not be rejected.

Conclusion: There was not a difference in orthopedic clients by severity of disability classification.

TABLE 26
ORTHOPEDIC BY RACE

	Black	White
fe*	1,080.03	4,062.97
fo	823	4,320

*Using the percentages of all Rehabilitation Services clients by race as the expected frequencies.

$\chi^2 = 77.42$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

TABLE 27
ORTHOPEDIC BY SEVERITY OF DISABILITY CLASSIFICATION

	Non-severely Disabled	Severely Disabled
fe*	2,571.5	2,571.5
fo	2,620	2,523

*Using the percentages of all Rehabilitation Services clients by severity of disability classification as the expected frequencies.

$\chi^2 = 1.82$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Mental, Psychoneurotic and Personality Disability

This category includes psychoneurotic and personality problems, specific learning disabilities, mental retardation, alcoholism and drug addiction. A comparison of all clients in this disability category is provided first (Table 28).

TABLE 28

MENTAL, PSYCHONEUROTIC AND PERSONALITY DISABILITIES BY GENDER,
RACE AND SEVERITY OF DISABILITY CLASSIFICATION (SEVERELY
DISABLED [SD] AND NON-SEVERELY DISABLED [NSD])

	Female		Male		Total
	Black	White	Black	White	
NSD	338	367	1,033	1,095	2,830
SD	523	469	1,269	1,447	3,708
Total	861	469	2,302	2,542	6,541

Clients in this disability category were compared by gender, race, and severity of disability classification. Table 29 presents the comparison by gender.

Result: Since the calculated chi square of 1059.19 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in female and male clients in this disability category when clients were compared by the

percentages of all Rehabilitation Services clients in FY 1985. Female clients make up only 26% of this category while they represent 44% of the total sample.

TABLE 29
MENTAL PSYCHONEUROTIC AND PERSONALITY DISABILITIES BY GENDER

	Female	Male
fe*	3,008.86	3,532.14
fo	1,697	4,844

*Using the percentages of all Rehabilitation Services clients by gender as the expected frequencies.

$\chi^2 = 1,059.19$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Clients in this disability category were also compared by race using the chi square test (Table 30).

Result: Since the calculated chi square of 2950.65 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in black and white clients in this disability category when compared by the percentages for all Rehabilitation Services clients in FY 1985. There appears to be a higher rate of blacks in this category than the would be expected since they make up 48% of this category but only 21% of the sample.

TABLE 30
MENTAL, PSYCHONEUROTIC AND PERSONALITY
DISABILITIES BY RACE

	Black	White
fe*	1,373.61	5,167.39
fo	3,163	3,378

*Using the percentages of all Rehabilitation Services clients by race as the expected frequencies.

$\chi^2 = 2950.65$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Clients in this disability category were then compared by severity of disability classification (Table 31).

Result: Since the calculated chi square of 117.04 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in clients in this category by severity of disability classification when compared by the percentages for all Rehabilitation Services clients in FY 1985. More clients were classified as severely disabled than non-severely disabled. Clients classified as severely disabled comprised 57% of this disability category although they made up 50% of the total number of clients listed as having a disability.

TABLE 31

MENTAL, PSYCHONEUROTIC AND PERSONALITY
DISABILITIES BY SEVERITY OF
DISABILITY CLASSIFICATION

	Non-severely Disabled	Severely Disabled
fe*	3,270.5	3,270.5
fo	2,833	3,708

*Using the percentages of all Rehabilitation Services clients by severity of disability classification as the expected frequencies.

$\chi^2 = 117.04$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Nervous System

This disability includes epilepsy, chronic brain syndrome and other disorders of the nervous system. It does not include multiple sclerosis, cerebral palsy, spinal cord injuries, or muscular dystrophy.

The clients in this disability category were compared by gender, race, and severity of disability classification (Table 32).

TABLE 32
NERVOUS SYSTEM DISABILITIES IN FY 1985

	Female		Male		Total
	Black	White	Black	White	
NSD*	7	29	11	31	78
SD	37	228	60	300	625
Total	44	257	71	331	703

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

Clients in this disability category were initially compared by gender (Table 33).

Result: Since the calculated chi square of 2.85 does not exceed 3.84, the null hypothesis may not be rejected.

Conclusion: There was not a significant difference in clients in this disability category by gender.

Clients in this disability category were then compared by race (Table 34).

TABLE 33
NERVOUS SYSTEM BY GENDER

	Female	Male
fe*	323.38	379.62
fo	301	402

*Using the percentages of all Rehabilitation Services clients by gender as the expected frequencies.

$\chi^2 = 2.85$ χ^2 rejection values for 1DF: $p.05 = 3.84$

TABLE 34
NERVOUS SYSTEM BY RACE

	Black	White
fe*	147.63	555.37
fo	115	588

*Using the percentages of all Rehabilitation Services clients by race as the expected frequencies.

$\chi^2 = 9.12$ χ^2 rejection values for 1 DF: $p. 05 = 3.84$

Result: Since the calculated chi square of 9.12 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in clients in this category by race when compared by the percentages for all Rehabilitation Services clients in FY 1985. More were white than would be expected.

Then, clients in this disability category were compared by severity of disability classification (Table 35).

TABLE 35
NERVOUS SYSTEMS BY SEVERITY OF
DISABILITY CLASSIFICATION

	Non-severely Disabled	Severely Disabled
fe*	351.5	351.5
fo	78	625

*Using the percentages of all Rehabilitation Services clients by severity of disability classification as the expected frequencies.

$\chi^2 = 425.61$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Result: Since the calculated chi square of 425.61 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in clients in this category by severity of disability classification when

compared by the percentages for all Rehabilitation Services clients in FY 1985. More were classified as severely disabled than would be expected.

Genito-urinary

This category includes end-stage renal failure. Hysterectomies are generally not listed under this disability code but under codes 608 and 609.

Clients in this category were compared by gender, race, and severity of disability category (Table 36). Then clients in this category are compared by gender using the chi square test (Table 37).

TABLE 36
GENITO-URINARY DISABILITIES IN FY 1985

	Female		Male		Total
	Black	White	Black	White	
NSD*	133	634	11	61	839
SD	20	50	22	44	136
Total	153	684	33	105	975

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

Result: Since the calculated chi square of 623.19 exceeds 3.84 the null hypothesis may be rejected at the .05 level of significance.

Conclusion: There was a significant difference in clients in this category by gender when clients were compared by the percentages for all Rehabilitation Services clients in FY 1985. Female clients made up 86% of this disability category. This can also be compared to the 61% reported by Smith and Gabe (Table I.A.1, 1984).

TABLE 37
GENITO-URINARY BY GENDER

	Female	Male
fe*	448.5	526.5
fo	837	138

*Using the percentags of all Rehabilitation Services clients by gender as the expected frequencies.

$\chi^2 = 623.19$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Clients in this category were also compared by race as shown in Table 38.

Result: Since the calculated chi square value of 2.16 does not exceed 3.84, the null hypothesis may not be rejected.

Conclusion: There was not a significant difference in clients in this disability category by race.

Clients in this category were also compared by severity of disability classification as shown in Table 39.

Result: Since the calculated chi square of 506.88 exceeds 3.84, the null hypothesis may be rejected at the .05 level of significance.

TABLE 38
GENITO-URINARY BY RACE

	Black	White
fe*	204.75	770.25
fo	186	789

*Using the percentages of Rehabilitation Services clients by race as the expected frequencies.

$\chi^2 = 2.16$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

TABLE 39
GENITO-URINARY BY SEVERITY OF DISABILITY CLASSIFICATION

	Non-severely Disabled	Severely Disabled
fe*	487.5	487.5
fo	839	136

*Using the percentages of all Rehabilitation Services clients by severity of disability classification as the expected frequencies.

$\chi^2 = 506.88$ χ^2 rejection values for 1 DF: $p.05 = 3.84$

Conclusion: There was a significant difference in the clients classified as having a genito-urinary disorder by severity of disability classification when compared by the percentages for all Rehabilitation Services clients in FY 1985. Non-severely disabled clients comprised 86% of this disability category.

Expenditures

The total expenditures for all clients closed as rehabilitated were compared by gender, race and severity of disability classification. The total expenditures for all 3,946 rehabilitants were \$9,847,654.53. Female clients received 50% of the total expenditures, white clients received 85% of the total expenditures, and non-severely disabled clients received 51% of the total expenditures.

Rehabilitants were then examined by average expenditures per client as shown in Table 40. The average expenditure per rehabilitant was \$2,495.60. The average expenditure for female clients was \$2,566.99 as compared to \$2,428.91 for male clients. The average expenditure for black clients was \$2,142.80 as compared to \$2,573.01 for white clients. The average expenditures for non-severely disabled clients was \$2,270.36 as compared to \$2,782.05 for severely disabled clients.

From comparing percentages for severely disabled black female clients, non-severely disabled black female clients, etc., it appears that proportionately less money was spent on severely disabled black female clients and non-severely disabled

black males as well as non-severely disabled white males while proportionately more money was spent on white female clients and severely disabled white male clients. Since the exact expenditure per client was unavailable, more specific comparisons could not be made.

TABLE 40
AVERAGE COST (EXPENDITURES) OF REHABILITANTS IN
FY 1985 BY GENDER, RACE AND SEVERITY OF
DISABILITY CLASSIFICATION

	Female		Male	
	Black	White	Black	White
NSD*	2,421.54	2,570.28	1,747.20	2,031.71
SD	2,026.10	2,743.93	2,370.57	3,050.40

*Using NSD to indicate non-severely disabled clients and SD to indicate severely disabled clients.

Thus, clients were compared by types of disabilities, expenditures, and incomes at application and closure, as well as by work statuses at closure. As noted above, there were differences found between client groups when clients were compared by gender, race, and severity of disability classification.

CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

To summarize the findings of this study, the primary objectives of the study will be reviewed.

Evaluation of the Primary Objectives

The evaluation of the three primary objectives is presented by stating the objectives and then stating the conclusions.

1. To determine if there is discrimination against subgroups of Tennessee Rehabilitation Services clients (by gender, race and/or severity of disability classification).

- a. Counselor questionnaires were judged as indicating bias due to counselors' own failure to follow agency policy when serving handicapped clients. Counselors showed more concern for closing cases in Status 26 as rehabilitated than for making sure the clients were actually rehabilitated. This affects length of time services are offered, the types of services that are offered, the amount of funds expended, the reasons for closure and adherence to manual guidelines.
- b. Client data showed bias by gender, by race, and by severity of disability classification. However, the amount of bias in earned income after rehabilitation was much less than the bias in earned

income by gender, and by race among the general population of Tennessee.

Gender

While females at closure were more likely to be making minimum wage, their average income was less than their male counterparts despite the fact that more money was spent to rehabilitate them. This was true even though non-severely disabled women earned more at application than any other group. At closure non-severely disabled women in paid work statuses earned less than severely disabled women. The opposite was true for males. Of those who were closed as rehabilitated but not earning money, 91% were female. Fewer female SSDI/SSI recipients were closed as rehabilitated. However, female SSDI/SSI recipients earned more money at closure than their male SSDI/SSI counterparts in that they more often earned SGA (\$300 a month). Also, although males were more likely to be closed as rehabilitated, they were less likely to be earning minimum wage.

Race

Black clients earned less money after rehabilitation than white clients. Furthermore, less money (in terms of average expenditure) was spent on the rehabilitation of black clients than on white clients. Moreover,

fewer black clients were maintained in the system until they were successfully rehabilitated.

Severity of Disability Classification

More severely disabled than non-severely disabled clients were closed as unpaid. Severely disabled clients were less likely to earn minimum wage at Status 26 closure. Severely disabled black and white male clients averaged less income than their non-severely disabled counterparts at Status 26 Closures. (This was not true for female clients.)

2. To determine if cost/benefit analyses (in terms of case expenditures and client salaries at closures) reveal adequate use of funds.
 - a. Overall, rehabilitants' annual total income was 2.7 times as great as applicants'. Moreover, the average rehabilitant had an income 7.5 times as much as the average applicant.
 - b. At application, all client groups averaged monthly incomes below poverty level. At Status 26 closure, all client groups in paid work statuses averaged incomes above minimum wage.
 - c. The average expenditure per rehabilitant was \$2459.60. In return the average annual income per rehabilitant was \$7,750.53. (In 1985 the federal income tax for a one person household [the typical Rehabilitation Services client household size for FY 1984] earning \$7,750 was

\$552.) Those clients earning incomes at closure will return tax dollars that will equal the amount expended on their rehabilitation in 4.45 years. In an additional .43 years these wage earners will pay enough taxes to even cover the amount expended on those rehabilitatants not earning incomes. This does not, of course, include the amount in tax dollars saved by removing individuals from SSDI and welfare rolls.

Clients who were not closed as rehabilitated were not included in this study. Therefore, information regarding funds expended on them was not available. From the review of the data in this study, it appears that, overall, Tennessee benefited from the Rehabilitation Services program and, generally, funds were well used for rehabilitants. However, this should not be taken as indicating that there is no room for additional improvement.

3. To ascertain Tennessee Division of Rehabilitation Services counselors' perception of service equity and effectiveness as well as recommendations for improving service delivery.

- a. Eighty percent of the counselors who responded to the questionnaire indicated more effective services would be provided if counselors did not have to worry about meeting the quota for Status 26 closures.

- b. The examination of counselors' perception of service equity did not give definite direction for specific conclusions.
- c. Counselors' recommendations for improving service delivery are presented later in this chapter.

Integration of Past and Present Research

Fletcher (1986) and Bowe (1985) as well as Wright and Weinberg-Asher (as reported in Steger, 1986) expressed concern that all handicapped individuals are victims of bias. Halcomb (1984), Kaplan (1984), Atkins (1982), and Russo and Denmark (1984) all reported additional bias toward handicapped women. In this present research stereotypical beliefs regarding females were not reflected in the counselor questionnaires. However, there is concern due to the fact that 91% of the unpaid rehabilitants were females. This figure can be compared to the report from the Rehab Group (Table A-1, 1979) that 40.7% of women with occupational disabilities chose to be homemakers. Also, this investigator found that 48% of the unpaid rehabilitants were severely disabled as compared to 16.7% as reported by the Rehab Group (Table A-1, 1979). Thus, this research re-emphasized past concerns for females being closed as unpaid rehabilitants. Further comparison can be made to Thurer's (1982) report for FY 1976 that 4% of the male clients were homemakers and 30% of the female clients were homemakers. For the current study, 14% were female and 1% male..

Hills (1972) provided the definition of, reasons for, and resultant concerns for counselor creaming. This research study reflected Hills'

report that it does exist and that eligible clients may not be served as a result. Furthermore, the current study indicated counselor creaming may result in a failure to carry out agency goals and manual guidelines. Further research is recommended to determine the full extent of the problem and determine ways to resolve the problem.

Moreover, Patterson's concerns (as expressed in Hills, 1972) about coercing clients into available employment for expediency was reflected by questionnaire items in which 57% of the counselors indicated that cases are closed due to quota requirements rather than because clients were appropriately employed and 53% indicated clients are more likely to be placed in a few main job categories in order to quickly meet quotas.

An additional concern as expressed by Pitts (1980), Growick (1976), Mottola (1973), Flynn (1975), and Bowman and Micek (1973) was that clients do not appear to have improved employment as a result of services. Since central office staff were unable to provide the data related to occupations at closure, this concern could not be addressed by the present research. However, it is recommended that future research be done to determine whether or not this is a major issue for Tennessee Division of Rehabilitation Services clients.

Bolton (1981) and Hull (1979) reported that clients need to be evaluated and served individually. Steger (1981) reported counselor bias in developing vocational evaluation when clients were compared by gender. The current research indicated Individualized Written Rehabilitation Program goals are ignored and changed after services are provided in order to meet Status 26 quotas. Furthermore,

questionnaire items indicated clients are placed in a few main training categories and also indicated unemployed clients are closed as unpaid domestic help, homemakers, unpaid family workers, etc., when jobs cannot be found.

Atkins (1982) recommended women be given individualized training and/or placement even if this in in non-traditional employment. Both Steger (1981) and the Rehab Brief (January 1983) reported that disabled women receive inadequate counseling. Atkins (1982) and Galther (as reported in Atkins, 1982), as well as Kriegsman and Cellota (as reported in the Rehab Brief, January 1983) stated that women need to receive assistance in self-awareness and assertion as well as self-awareness and relationship building. However, this investigator was unable to evaluate this area due to an inability to review records. It is strongly recommended that the agency investigate this potential problem in the future to assure that appropriate individualized services are provided.

Also, Atkins and Wright (1980) reported that black clients received less training and were closed as earning less money than white clients. This investigator was unable to obtain the data necessary to evaluate training. Since expenditures are reported to central office staff for training, there may be a way to report the specific types of services with a few changes in the computer program so that future research can be done in this area. This investigator did find that black clients averaged fewer dollars spent on their rehabilitation.

Malik (1973/1974) reported that occupations and salaries were reflected by gender and race. Vash (1982), Oppenheimer (as reported in

Steger, 1981), Daniels (1981), Thurer (1982), Ferraro (1984), the Rehab Brief (1983), and Kahl (1983) all reported gender influences on occupations and salaries. Tinsley and Gaughan (1975) reported occupational shifts as a result of services. Bowe (1983) reported that women were generally employed in clerical or service areas while men were more evenly distributed among occupations. Malik (1973/1974) reported black individuals were generally employed in private household service. Unfortunately, central office staff were unable to provide the necessary data for this comparison. This area needs to be evaluated to determine if female and black Rehabilitation Services clients are appropriately assisted towards competitive employment. Thus, occupations as well as incomes at closure should be examined for individual clients. This might help determine why only 47% of the rehabilitants earned minimum wage.

Additional concerns regarding income were expressed. Schrodell and Jacobsen (1978) reported that disabled individuals are often in less prestigious jobs with lower pay. Bowe (1985) reported that disability is prevalent among disadvantaged individuals. Pearch and McAdd (as reported in Ferraro, 1984) stated that women's incomes are barely above the poverty level. This investigator found that all client groups' average incomes were below the poverty level at application. However, all averaged minimum wage or above at closure.

Russo and Denmark (1984) stated that women earned less money than men. McNeil (1982) reported that females earned 42% of that earned by males. The Rehab Brief (1983) reported that females earned 56% of that earned for males. This study found that female clients earned 72% of

that earned by males. Weiss (1985) reported an average wage gap between white men and black women as \$9500. The data for this study revealed a difference of \$3100. Thus, while there were inequities, Tennessee Rehabilitation Services clients had more equitable incomes than comparable groups. This was true even when compared to median incomes for all Tennesseans as shown in "Women in the Labor Force" (1984).

Although female and black Rehabilitation Services clients in Tennessee may have compared more favorably than other groups, research is still needed to further evaluate these two factors in overall financial improvement as a result of rehabilitation. Since women are often single parent heads of households with low incomes, research needs to be done to evaluate marital status, race and gender of the head of the household, and the rate of increase in incomes of clients from application to rehabilitation. Thus, rather than simply reaffirm previous research, this study reflected a need for additional detailed research in the future. Furthermore, actual services need to be compared to determine what benefits clients actually receive.

A Caution

The findings as reported above need to be considered in light of the additional information regarding Tennessee Rehabilitation Services' report of closures that was provided by the Comptroller's office as a result of a Sunshine Audit. In a memorandum to regional and district supervisors, Sharrer (1986) included a summary of the findings of the audit. The summary concluded that a review of the cases closed as successful rehabilitants for state FY 1983 showed

that 33.3% of the files did not document that case closures were successful rehabilitations. Furthermore, in 11% of the cases, auditors stated contact persons (relatives, clients, or employers) claimed that the clients had not been employed or had been employed for only a short time.

Implications

At present counselor creaming is a primary concern in examining the rehabilitation process. The intent of rehabilitation legislation may be taking second place to the need for counselor job security. Counselors may need incentives to motivate them towards equity rather than quotas. These incentives may include more resources for renewal such as conferences, quality circles, better opportunities for use of individual abilities, and developing unity of purpose through inclusion in policy making.

While the clients who have been placed in competitive employment were benefited by the program and in turn benefited the community, the question remains "Can we better serve individuals with vocational handicaps". This study does not prove that simply eliminating quotas would increase the number of rehabilitants. However, developing and implementing additional criteria for evaluating successful closures related to meeting Individualized Written Rehabilitation goals and other manual guidelines may reduce the number of questionable closures.

The investigator found very few proposals for changes in the evaluation of the rehabilitation process. These included an

article by Cooper and Harper (1979), a letter to the investigator from Seifker (1985), and ratings by counselors of suggestions listed on the questionnaires. Cooper and Harper (1979) discussed the possibility of developing a weighting system for such outcome variables as closure status, work status at closure, earnings at closure, specific demographic and disability characteristics, unemployment rate in the client's area, and presence of multiple disabilities. In a letter to this investigator Siefker (1985) stated that point systems have not worked in the past in Tennessee. This was primarily because one counselor could serve several easy closures and obtain more points than another counselor who served a few very severely disabled clients. However, this may have failed due to giving too few points to difficult factors in rehabilitation. Also, due to the new order of selection guidelines (see Appendix F), giving first priority to severely disabled clients, there may be a smaller differential in examining difficulty of rehabilitation.

The data from this study indicates black clients may not be provided sufficient incentives to stay in the system and obtain maximum benefit. Moreover, female and severely disabled clients, as compared to other groups, may be more likely to be routed to non-competitive financially unsuccessful endeavors. Steps need to be taken to insure that clients are served as individuals and provided opportunities to meet their individual goals as jointly established on the Individualized Written Rehabilitation Program. In order to reduce the probability of clients not receiving appropriate services, a system may need to be developed to enhance

the likelihood for assisting clients to reach their full potential within feasible guidelines. This might include setting up a task force to determine employment needs within the community while advocating the hiring of individuals with handicaps, particularly those who are minorities, referrals to the Employer Representative to provide additional placement assistance, and in-service training to counselors to assist them in becoming more aware of stereotyping clients for any reason.

Suggestions from Cooper and Harper (1979) include evaluating service outcome by intangible outcomes such as independent living skills, psychosocial adjustment, and client satisfaction. They also considered using the Individualized Written Rehabilitation Program as an evaluation tool but decided that due to the possibility of amendments, etc., the Individualized Written Rehabilitation Program would reflect the history of the case rather than being a planning tool. However, in light of this investigator's findings, this might be an excellent tool for evaluating whether clients' goals were met, appropriate services were provided, and the plan for each client accomplished. It is important that counselors accept the Individualized Written Rehabilitation Program as a contract on their part as well as the client's. Furthermore, client evaluation of the rehabilitation process would reinforce the importance of client satisfaction to overall successful rehabilitation.

Counselors were asked to rate possible steps for improving service delivery to clients. A majority of the counselors agreed

to the following for improving the rehabilitation process: providing skills for clients to become able to obtain their own employment (99%), increasing public education programs regarding Rehabilitation Services and resulting benefits to the community (99%), teaching clients self-reliance (97%), improving relations with referral agencies to reduce inappropriate referrals (97%), serving the clients from a wholistic approach rather than concentrating on only the most limiting aspect of the disability (90%), reducing band-aid therapy (77%), increasing opportunities for clients to have input into their program (76%), providing minimal maintenance payments to avoid creating client dependency on unstable funding (76%), including more counseling courses in Rehabilitation Services training (72%), increasing the number of employer representatives (64%), separating independent living skills from the rehabilitation program (57%), emphasizing serving severely disabled clients rather than concentrating on quick Status 26 closures (56%), following the manual exactly rather than having to justify past expenditures (55%), and increasing opportunities for clients to have input into the Rehabilitation Services program in general (55%). Counselors did not believe the following would improve the process: providing the fewest services necessary to rehabilitation clients (41%), doing minimal diagnostic evaluation to determine feasibility (32%), or establishing homemaker/unpaid family workers as a separate program from the rehabilitation program (32%).

There are further suggestions for enhancing services. Counselor in-service training could include the topics of socio-economic aspects

of disability; the additional consequences of gender, race (or possibly even age) on gaining rehabilitation services and employment opportunities; and the importance of adhering to manual guidelines.

Moreover, additional client service criteria could be given consideration. These include specific criteria for homemaker closures (see Appendix D for general ideas) and clients' evaluation of the program (see Appendix E for one example). Also, advisory committee and counselor input could be of value to administrative staff.

The investigator did not find research showing that the quota system is the most or least effective means of evaluation. However, using numbers as criteria to measure services to people appears to be negative and may be one factor in not seeing clients needs as important in the rehabilitation process. Since Tennessee Rehabilitation Services counselors indicated that due to quota requirements they are not following manual guidelines, it appears vital that a means be developed to insure that federal and state guidelines are implemented. Steps need to be taken to improve the present method of analyzing data.

At present Tennessee's statistical reporting system does not provide a means to evaluate an individual client's financial, social, psychological, or physical progress from application to closure. A method needs to be developed to analyze current data by client groups in terms of rate of income increase, possibly change in Dictionary of Occupational Titles classification from application to closure, and types of services as well as length of services.

Furthermore, it could help to develop a case review system enabling reviewers to evaluate service outcome rather than simply relying on the rate of increase in statuses such as the number of applicants or number of new plans developed. This investigator is not recommending the end of the present system but the development and implementation of additional evaluation tools. For example, an additional section could be included on the counselor evaluation forms to rate the counselors' adherence to manual guidelines or adherence to Individualized Written Rehabilitation Program agreements. Moreover, client ratings could be used to evaluate clients' perception of program effectiveness and equity.

Administrative support for viewing clients as individuals with needs and potential rather than numbers is crucial. Counselors may not have intentionally failed to serve clients. In the recent past, dollars have been stretched further in an effort to serve more clients. Counselors have sought to return the most dollars for the money spent. They should be commended for their efforts. However, this does not negate their responsibility to serve clients.

The results of this study indicate the agency is a microcosm of our society in its attitude towards individuals with disabilities, blacks and females. However, this is not to be used as an excuse for not providing the best possible service delivery to clients. For example, steps should be taken to assure that more than 47% of the rehabilitants are earning minimum wage at closure. Counselors should be encouraged to increase opportunities for clients and become more effective advocates for handicapped individuals in the

community rather than unknowingly or involuntarily remaining part of the structure that is limiting clients in becoming gainfully employed and/or more independent.

The Study from the Investigator's Perspective

This investigator initiated the research to determine if clients were provided essential services or were lost in the bureaucratic paperwork. At various times the investigator had been encouraged by fellow staff members to view clients as a means to meet agency needs rather than vice versa. The investigator became concerned that clients moves through the system without becoming competitively employed or gaining other long-term benefits from the program.

During the time the investigator worked for the agency, comments had been made that women were provided hysterectomies or dental work as quick and easy closures while men were encouraged to receive training since they were the breadwinners. Furthermore, the investigator's primary emphasis in the doctoral program was in gender and ethnic issues in counseling and teaching. Therefore, the investigator chose to study the impact of clients' gender and race on client services. Since the investigator had heard that many people were screened out prior to application because their rehabilitation would be costly or lengthy, the investigator chose to also include this concern in the study. Severity of disability was a related issue since these clients often need extensive service to reach their vocational potential and objectives. The investigator expected, therefore, to find some

counselor creaming and counselor stereotyping but was uncertain as to the extent.

The investigator realized that often in a bureaucracy an employee may 'stretch' numbers but also recognized at the same time counselors do rehabilitate clients. They often provide quick and easy services to some clients in order to be able to risk time and money on more difficult clients. The investigator is not stating that the former clients are not eligible for services. Enabling any individual to be productively employed benefits the individual and the community. However, these clients may eventually have been able to work without the agency's assistance. Therefore, the investigator was concerned that the agency needs to be sure it helps those clients who would not become employed or appropriately rehabilitated without the program.

Furthermore, in reading the literature, the investigator became even more aware of the need for effective service delivery since many disabled individuals are below the poverty level. The agency can be an important factor in enabling tax users to become tax payers. Therefore, the investigator chose to examine all these factors in the rehabilitation process.

After reviewing the rehabilitation legislation and manual guidelines the investigator became more convinced of the value of the organization and its goals. However, the operations part of the agency has some weakness in that counselors report they receive more encouragement to provide numbers than services. There appears to be a great need for routine evaluation of the rehabilitation process to determine if agency goals and policy are implemented.

The research data indicated that all client groups improved substantially economically. However, only 47% of the rehabilitants earned minimum wage at closure. Therefore, the investigator believes that while the agency has benefited clients, more research needs to be done to determine how to enable even more clients to become productively employed.

While the investigator expected to find counselor stereotyping of clients, the independent raters did not find stereotyping other than in terms of counselors' indicating SSDI/SSI clients lack motivation for rehabilitation and severely disabled clients can be more effectively rehabilitated by being trained to work at home. However, the investigator and reviewers agreed that there was counselor creaming.

Furthermore, the investigator was unable to obtain data regarding services provided in terms of training, physical restoration, etc. Therefore, there are still questions as to whether clients groups receive different services based on their gender or race.

In conclusion, the investigator found that the Tennessee Division of Rehabilitation Services is of service to individuals with disabilities and to the community. However, much remains to be done regarding individualizing clients and striving to meet their needs rather than simply reaching quotas. Research still needs to be done to determine ways to make the process effective for all clients. As a result of the study, the investigator has a more positive attitude towards the agency as a whole. However, it is hoped that a means of establishing on-going evaluation will be developed and will lead to

better implementation of rules and regulations as a result of this research.

Future Research

There is a need for additional state and federal research in this area of the rehabilitation process. Research is needed for developing a system for compiling data to evaluate service effectiveness. Furthermore, the system needs to be designed to make retrieval by gender, race, age, etc., easy. Combining these types of data with traditional data for annual reports could improve service delivery and provide added substance to requests to Congress for increased funding. However, these methods for collection and reporting need to be standardized so that accurate reporting can occur. Furthermore data may need to be examined in such a manner that would reveal what is or can be done to improve and maintain the provision of quality services.

The agency needs to determine further the impact of its quota system on services provided. This study has initially shown that manual guidelines are ignored. However, it has not shown that eliminating quotas completely would solve the problem. Further research is needed to determine whether the quota system has resulted in more clients being served or if it has been an excuse for poor performance in terms of rehabilitation counseling and service delivery. Steps may need to be taken to assure that production and quality are both maintained.

In the past many supervisors have told the researcher they are concerned that eliminating production quotas would result in reduced counselor efforts to serve clients. Therefore, research may need to be done after implementing quality guidelines to measure the number of cases served, adherence to manual guidelines, overall increase in client incomes, and client satisfaction. This would enable the agency to determine whether eligible clients are served appropriately without the agency losing overall productivity. However, if numbers of clients are reduced because ineligible clients are no longer served and cases are no longer closed with services not being provided, the agency may need to decide if the quotas were valuable as previously met.

If past research on the positive impact of production quotas can be found, the agency may wish to merge them with this research to develop methods of enhancing the overall rehabilitation process. Tennessee's Rehabilitation Services program may benefit from developing a process for counselors to express thier opinions and concerns. For example, counselors' current concerns with the difficulty of providing services to severely disabled clients and the length and the cost of services as crucial even after feasibility is established should be addressed. The agency may choose to compare these factors for rehabilitated clients versus non-rehabilitated clients to determine if this is sufficient justification for refusing services and possibly changing policy as a result.

While counselors are correct in not wanting to waste money, they may not be providing the services that would make a difference in whether a particular case was a success or failure. Therefore,

research may be needed to assess the impact of client expenditures and other services. The investigator realizes that sometimes only one short service may have great impact on an individual client. However, the agency is increasingly receiving requests for costly services. The agency needs, therefore, to determine whether eligible clients should be denied access to the program due to the cost of rehabilitation. Eligibility criteria may need to be changed or augmented to meet funding limits or agency goals.

Furthermore, additional factors should be evaluated as predictors for successful closures. For example, client satisfaction, rate of increase in income from application to closure, whether or not manual guidelines for homemaker, unpaid family worker, and competitive employment are actually met when clients are closed as successfully rehabilitated, employment as a result of training, and weighting for difficulty of service delivery may all be viable predictors for successful closure. Other topics of future research should include the types and length of services provided, (such as that reported by Atkins and Wright [1980]), comparison of rehabilitants to non-rehabilitants, possible relationship of type of disability to occupation and income at closure, and whether or not clients are provided sufficient data regarding opportunities for improving employment potential so they can request appropriate assistance. Also, researchers may choose to further study the impact of counselor attitudes on service delivery. Furthermore, research may be needed to see if vocational objectives as stated on the Individualized Written Rehabilitation

Program reflect the vocational abilities and interests found in the vocational evaluations.

Rehabilitation Services in the Future

In reviewing the research, it appears that the basic problem lies not in the goals or organization of the program but in the operation of the program. The agency needs to determine whether day to day operations reflect a consistent and unifying focus on goal attainment as recommended by Bellon and Handler (1982). Bellon and Handler explained that "current practices should be regularly analyzed to ensure that tradition and convenience do not determine what takes place" (p. 54) but are implementation of agency policy. Rehabilitating clients should be the primary daily focus for counselors. Transferring the recommendations made by Bellon and Handler from the field of instruction to rehabilitation, it may be said that improvement in the operations phase of the program should be a systematic, high priority activity guided by positive assumptions about counselor behavior. They further concluded that administrators have a major leadership role in improving operations activities.

On going evaluation of the system is essential in terms of assuring continuity of service delivery and in establishing new goals and priorities when needed. The basic framework for improvement lies in program evaluation and development, personnel evaluation, and staff development. Furthermore, it is important that personal and organizational goals are met in ways that are rewarding to both staff and agency. In addition both the need to value accountability and

assure that regional and district goals reflect agency policy should be addressed.

This is not a recommendation for "cadillac" rehabilitation but a realistic request to enhance the client's ability to function as an individual in the community financially, socially, etc. Enabling clients to become more independent would result in increased revenues as well as intangible benefits to the community. Benefits to counselors could include increased respect and pride for improving the conditions of other human beings as well as good evaluations from supervisors. The agency would be able to provide additional justification for its existence. (It is important to remember that rehabilitation laws do not specify the number of clients who must be closed annually or the number of secretaries, lawyers, etc., who must be supplied to employers.)

It appears that Tennessee Rehabilitation Services is at a crossroads. Administrative staff may wish to evaluate past, present, and future policy and procedures. They may ask, "Is the agency's goal the implementation of the spirit of rehabilitation legislation or the generation of statistics?" The agency has the authority and responsibility to determine its goals. However, these goals and means of implementation need to be stated clearly to the community so that individuals can use the services appropriately. It is the hope of this investigator that the agency's goal is and will remain to increase and enhance opportunities for individuals with disabilities.

LIST OF REFERENCES

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- Atkins, B. J. (1982). Women as members of special populations in rehabilitation. In L. G. Perlman and K. C. Arneson (Eds.), Women and Rehabilitation of Disabled Women. Alexandria, Virginia: National Rehabilitation Association.
- Atkins, B. J., & Wright, G. N. (1980). Vocational rehabilitation of blacks. Journal of Rehabilitation, 46(2), 40-46.
- Bellon, J. J. & Handler, J.R. (1982). Curriculum Development and Evaluation: A Design for Improvement. Dubuque, Iowa: Kendall/Hunt Publishing Company.
- Bolton, B. (1981). Assessing employability of handicapped persons: The vocational rehabilitation perspective. The Journal of Applied Rehabilitation Counseling, 12(1), 40-44.
- Bowe, F. (1983). Demography and disability--A chartbook for rehabilitation. Hot Springs, Arkansas: Arkansas Rehabilitation Research and Training Center.
- Bowe, F. (1985). Jobs for disabled people. New York: Public Affairs Pamphlet (#631).
- Bowman, J. T., & Micek, L. A. (1973). Rehabilitation service components and vocational outcome. Rehabilitation Counseling Bulletin, 17(2), 100-109.
- Bye, B., & Schechter, E. (1980). Technical introduction, Nineteen Seventy-eight Survey of Disability and Work. (SSA Publication No. 13-11745). Washington, DC: U.S. Government Printing Office.
- Carrick, M. M., & Bibb, T. (1982). Disabled women and access to benefits and services. In L. G. Perlman & K. C. Arneson (Eds.), Women and Rehabilitation of Disabled Women. Alexandria, Virginia: National Rehabilitation Association.
- Cooper, P. G., & Harper, J. N. (1979). Issues in the Development and Implication of a Case Weighting System. Journal of Applied Rehabilitation Counseling, 10(1), 7-11.
- Cooper, P. G., Harper, J. N., & Davis, S. (1980). Perceived outcome priorities in a state vocational rehabilitation agency. The Journal of Applied Rehabilitation Counseling, 11(1), 14-17.
- Cornett, S. J. (1984, September). The future of rehabilitation: The federal perspective. Rehabilitation Services Training Conference, Knoxville, Tennessee.

- Disability and consumer power. (1979, March--April). American Rehabilitation, 4(4).
- DRS Statistics 82. (1982). Tennessee Department of Human Services, Division of Rehabilitation Services.
- Ferraro, G. A. (1984, October). Bridging the wage gap--Pay equity and job evaluation. American Psychologist, 39(11), 1166-1170.
- Fletcher, M. L. (1986, March 20) Attitudes Regarding the Disabled Person (Report to TVA Advisory Committee for Homecoming '86). Knoxville, Tennessee.
- Flynn, R. J. (1975). Determinants of rehabilitation rate: A causal analysis. Rehabilitation Counseling Bulletin, 18(3), 181-191.
- Goodwill Industries Policy and Procedure Manual, Revised 1984.
- Grobe, P. (1981, Fall) Vocational rehabilitation: A comprehensive look. Unpublished paper. University of Tennessee, Knoxville.
- Growick, B. S. (1976). Rehabilitation outcome as a function of differential service patterns. Rehabilitation Counseling Bulletin, 20(2), 110-171.
- Guthrie, J. L., Crest, K., Sienicki, D. A., & Walls, R. T. (1981). Homemaker rehabilitation in the age of accountability. Rehabilitation Literature, 42(3-4), 90-94.
- Hanks, D. (1984, September). Trends and direction in rehabilitation: The research perspective. Rehabilitation Services Training Conference, Knoxville, Tennessee.
- Hills, W. G. (1972). Vocational rehabilitation: A study of goal displacement (Doctoral Dissertation, University of Oklahoma, 1972). Dissertation Abstracts International, 33, 1086A.
- Holcomb, L. P. (1984, January/February/March). Disabled women: A new issue in education. Journal of Rehabilitation, 50(1), 18-22.
- Hull, K. (1979). The rights of physically handicapped people. New York: Avon.
- Kahl, A. (1983, Spring). Characteristics of job entrants in 1980-81. Occupational Outlook Quarterly, 27(1), 18-26.

- Kaplan, S. P. (1984, January). Rehabilitation counseling students' perception of obese male and female clients. Rehabilitation Counseling Bulletin, 21(3), 172-181.
- Lynch, R. K. (1981). Functional factors related to vocational rehabilitation outcome: Implications for services providers and researchers. The Journal of Applied Rehabilitation Counseling, 12(3), 113-122.
- Malik, H. M. (1973/1974). A study of racism and sexism in career counseling, job selection and placement by vocational rehabilitation counselors in Alaska, Idaho, and Oregon. (Doctoral Dissertation, University of Oregon, 1973). Dissertation Abstracts International, 34, 6146A.
- Management Information System (1983). District performances as indicated by volume, effectiveness, cost and earnings measures; Districts grouped by supervisors--closed cases only--Period measures = Fiscal Year 1983, Tennessee Department of Human Services, Rehabilitation Services Division. (M.I.S. 2)
- Management Information System (1985). Districts grouped by region closed 10/01/84--09/30/85, Tennessee Department of Human Services, Rehabilitation Services Division. (M.I.S. 4)
- McGowan, J. F., & Porter, T. L. (1967). An introduction to the vocational rehabilitation process. Washington, DC: U.S. Government Printing Office.
- McNeil, J. (1982). Labor force status and other characteristics of persons with a work disability. (Stock No. 003-001-91542-1). Washington, DC: U.S. Government Printing Office.
- Mottola, L. F. (1973). Correlates of success in vocational rehabilitation. Dissertation Abstracts International, 33, 6250A-6251A (University Microfilm No. 73-10, 988)
- New Sources of Disability Statistics. (1984, March-April). Programs for the Handicapped. (Clearinghouse on the Handicapped. 2, 12-16.
- Nineteen-seventy-eight survey of disability and work: Data book. (1978) Washington, DC: U.S. Government Printing Office.
- Nineteen-eighty census of population: Detailed population characteristics. (1980). Tennessee --Table 80. Washington, D.C. U.S. Government Printing Office.
- Pitts, J. H. Predictors of rehabilitation success and failure of a caseload of hearing impaired clients. (1980). The Journal of Applied Rehabilitation Counseling, 11(4), 200-202.

- Randolph, A. H., & Minton, E. B. (1980). Reflection of rehabilitation. American Rehabilitation, 6(2), 3-6.
- Rehab Brief, (1983, January). 6(2), 3-6
- Rehab Group, Inc. (1979). Digest of data on persons with disabilities. (Stock No. 017-190-00050-0). Washington, DC: U.S. Government Printing Office.
- Russo, N. F., & Denmark, F. L. (1984, October). Women, psychology, and public policy--Selected issues. American Psychologist, 34(11), 1161-1165.
- Schenzinger, A. R. (1981) An alternative evaluation tool for the measurement of vocational rehabilitation counselor performance. The Journal of Applied Rehabilitation Counseling, 12(1), 27-31.
- Schroedel, J. G., & Jacobsen, R. J. (1978). Employer attitudes towards hiring persons with disability--A labor market research model. Albertson, New York: Human Resources Center.
- Siefker, W.D. (1985, July 26) Proposed Point System Chattanooga, Tennessee.
- Sharrer, C. J. (1986, January 30) Audit of Rehabilitated Cases (Memorandum to Regional and District Supervisors) Nashville, Tennessee.
- Smith, M. F., & Gabe, T. (1984, June). Digest of Data on Persons with Disabilities. Mathematica Policy Research, Inc., Washington, D.C.
- Social security bulletin, annual statistical supplement 1983. (1983). Washington, DC: U.S. Government Printing Office.
Washington, DC: Mathematica Policy Research, Inc.
- Steger, H. S. (1981). Gender stereotyping by vocational rehabilitation counselors. (Doctoral Dissertation, The Florida State University, 1981). Dissertation Abstracts International, 42, 1016A.
- Tennessee data for affirmative action plan 1984. (1984). Tennessee Department of Employment Security, Research and Statistics Division, Labor Market Information Unit
- Tennessee statistical abstracts of 1983/1984.
- Thurer, S. L. (1982). Women and rehabilitation. Rehabilitation Literature, 43(7-8), 194-197, 207.

- Tinsley, H. E. A., & Caughan, S. M. (1975). A cross-sectional analysis of the impact of rehabilitation counseling. Rehabilitation Counseling Bulletin, 18(3), 147-153.
- U.S. Department of Labor--Employment and Training Administration. (1977). Dictionary of Occupational Titles.
- Vash, C. L. (1982). Women and employment. In G. Perlman & K. C. Arneson (Eds.), Women and Rehabilitation of Disabled Women. Alexandria, Virginia: National Rehabilitation Association.
- Vocational Rehabilitation Data Base (1983). (File No. 2, Program 123).
- Vocational Rehabilitation Program Manual
- Weiss, C. (1985, March). Women and inequality in Appalachia: The effects of economic development. Paper presented at the Appalachian Studies Conference, Berea, KY.
- Whitten, E. B. (1974). The rehabilitation act of 1973 and the severely disabled. Journal of Rehabilitation, 40(4), 2, 39-40.
- Women in the labor force 1984. (1984). Tennessee Department of Employment Security, Research and Statistics Division, Labor Market Information Section.
- Work incentives for the disabled and blind under the social security and supplemental security income programs--A training aid for vocational rehabilitation counselors. (May 1985). Social Security Administration Office of Disability (SSA Publication No. 64-015).

APPENDIXES

APPENDIX A

INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM

INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM

1. NAME _____ PROGRAM TYPE ☐ INITIAL ☐ ADMENDMENT
2. YOU ARE ELIGIBLE FOR ☐ VOCATIONAL REHABILITATION SERVICES ☐ EXTENDED EVALUATION SERVICES ☐ POST EMPLOYMENT SERVICES
- BECAUSE: ☐ A YOU HAVE A PHYSICAL OR MENTAL DISABILITY WHICH CONSTITUTES A SUBSTANTIAL HANDICAP TO EMPLOYMENT AND
☐ B YOU CAN REASONABLY BE EXPECTED TO BENEFIT IN TERMS OF EMPLOYABILITY FROM VOCATIONAL REHABILITATION SERVICES
☐ C IT CANNOT BE DETERMINED WHETHER OR NOT YOU CAN BENEFIT IN TERMS OF EMPLOYABILITY FROM VOCATIONAL REHABILITATION SERVICES
☐ D POST EMPLOYMENT SERVICES ARE NEEDED FOR YOU TO MAINTAIN EMPLOYMENT
3. PROGRAM OBJECTIVE _____ ANTICIPATED DATE OF ACHIEVEMENT MONTH _____ YEAR _____
ESTIMATED DATES TO REACH OBJECTIVE & RECEIVE SERVICES
4. INTERMEDIATE OBJECTIVE SERVICES METHOD OF CHECKING PROGRESS _____ RESPONSIBILITY FROM TO _____
- OBJECTIVE _____
SERVICES _____
- METHOD OF CHECKING PROGRESS _____
- OBJECTIVE _____
SERVICES _____
- METHOD OF CHECKING PROGRESS _____
- OBJECTIVE _____
SERVICES _____
- METHOD OF CHECKING PROGRESS _____
5. CLIENT OR FAMILY AND AGENCY RESPONSIBILITIES AND CONDITIONS _____
6. CLIENT'S VIEW OF PROGRAM _____
7. I HAVE PARTICIPATED IN THE DEVELOPMENT OF THIS REHABILITATION PROGRAM AND I UNDERSTAND IT
I UNDERSTAND AND ACCEPT THE STATEMENT OF UNDERSTANDING WHICH HAS BEEN EXPLAINED TO ME

CLIENT, PARENT OR GUARDIAN'S SIGNATURE

DATE

COUNSELOR'S SIGNATURE

DATE

STATEMENT OF UNDERSTANDING

An individual is eligible for Vocational Rehabilitation services when it has been determined that (1) the person has a physical or mental disability which constitutes or results in a substantial handicap to employment and (2) that such persons can reasonably be expected to benefit in terms of employability from Vocational Rehabilitation services.

An individual is eligible for extended evaluation services when the person meets the condition of clause (1) above, but for whom it is not possible to determine that the person can reasonably be expected to benefit in terms of employability without the provision of extended evaluation services.

For each client who is eligible for Vocational Rehabilitation or extended evaluation services, an Individualized Written Rehabilitation Program (IWVP) is developed jointly by the client and counselor. It will include the steps to be taken to reach that goal and identifies the person or agency that will be responsible. In some cases the agency assumes some or all the responsibility; in others the client is fully responsible; and in others another agency is responsible. In most cases a combination of these is in effect. The initiation of some programs may be conditional on the availability of openings at facilities and schools. In many programs changes are required to take care of circumstances that cannot be foreseen. In no case can the agency guarantee that all programs initiated will be completed in a given time period, since public funds may become limited or exhausted, at which time the Agency's Order of Selection as stipulated by law, mandates that clients be served on a priority basis with the most severely handicapped receiving services first. Some programs may be ended prior to their completion if there is no longer a need for them due to new information and changing conditions, or if it is indicated that the client can no longer derive any benefit from them. The continuation of services in all cases is dependent upon ongoing evaluation and the likelihood of the client's ability to benefit in terms of employability.

There will be a periodic evaluation of the progress in the program and at least once each 12 months a review will be conducted at which time the client is given the opportunity for consultation if it is necessary to make substantial changes or redevelop the program or to change the client's status from eligible to ineligible.

It is the client's responsibility to cooperate in the program and make a reasonable effort to carry out its conditions. This includes: the keeping of appointments, attendance at scheduled activities, attaining acceptable ratings in training and other activities as carrying out medical and other professional instructions, etc. It is also the client's responsibility to report to the agency changes in financial circumstances or the available services or financial assistance from programs other than the Vocational Rehabilitation to meet, in whole or in part, the cost of services provided under an Individualized Written Rehabilitation Program. Failure to do so may result in ineligibility for further services.

If a client is dissatisfied with any action with regard to the furnishing or denial of Vocational Rehabilitation services, that person may file a request for an Administrative Review by a member of the supervisory staff. If dissatisfied with the findings of the Administrative Review, a fair hearing shall be granted before the State Administrator or his designee.

All services provided by the Division of Vocational Rehabilitation will be administered in such a manner that no individual shall be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination on the grounds of their race, color, sex, handicap or national origin. If an individual believes he or she has been discriminated against, he or she has the right to file a written complaint with the State Administrator, Division of Vocational Rehabilitation, 1808 West End, Nashville, Tennessee, or Department of Health, Education and Welfare, Regional Office, Atlanta, Georgia.

In certain parts of the State a Client Assistance Project is available to clients who experience misunderstandings or other difficulties with their program. The details of this project are explained to the client when the services are available.

APPENDIX B

IDENTIFICATION OF THE SEVERELY DISABLED

IDENTIFICATION OF THE SEVERELY DISABLED

General Instructions

Record for purposes of Order of Selection and R-300 coding as severely disabled individuals who meet any one of the following four categories:

1. Clients with major disabling conditions. See attachment 3005.03 (44)(a) through (e) for disability codes;

or

2. Clients who at any time in the vocational rehabilitation process had been Social Security Disability Insurance (SSDI) beneficiaries;

or

3. Clients who at any time in the vocational rehabilitation process had been recipients of Supplemental Security Income (SSI) payments by reason of blindness or disability;

or

4. Other individual cases with documented evidence of loss and/or limitation(s) meeting the criteria of Functional Limitation Factors. (Functional Limitation Factors are: Mobility, communication, self-care, self-direction, work tolerance, work skills.) In category four are those conditions, whether a single disability or a combination of disabilities, which when presented in terms of clinical description and functional

limitations, the State agency (counselor/medical consultant) can determine:

A. There exists substantial loss of functional capacity and/or restriction of activity attributable to medical factors, such that the client:

1. Is unable to make use of public bus or train, or
2. Is unable to perform sustained work activity due to intellectual, physical, emotional, behavioral limitations for six hours or more, or
3. Has disfigurement or deformity so pronounced as to cause social rejection, or
4. Speech is unintelligible to non-family members, or
5. Is unable to climb one flight of stairs or walk 100 yards on the level without pause, or
6. Has loss of manual dexterity or coordination sufficient that he is unable to button buttons, wind a watch or write intelligibly, or
7. Lacks basic skills of self-care--personal, social, financial, dependency, lack of foresight, planning for self-sufficiency, has impaired personal, social, and vocational judgment, or
8. Lacks basic skills of self-direction--choosing a job, setting goals, making appropriate decisions, choosing realistic careers, job seeking skills, and job retention skills, or

9. Lacks basic work skills--possesses minimum, if any useful work experiences, possesses minimum or no marketable skills; has poor work/work related habits, e.g., punctuality, appropriate appearance, etc., and
- B. The client will normally require multiple vocational rehabilitation services over an extended period of time.
1. Multiple vocational rehabilitation services are defined as two or more major VR services such as training, physical restoration, mental restoration, counseling and guidance (over and above the routine counseling and guidance that should take place in every case) placement, employment, follow up. Support services such as maintenance, transportation, incidental expenses, wardrobe, placement equipment, etc., would not be considered as major services.
 2. Extended period of time is defined as 12 months or more.

RSA Disability Code

100-119	Blindness, both eyes
120-129	Blindness one eye, other eye defective
140-149	Other visual impairments
	If, with correction, unable to obtain driver's license for visual reasons
231-259	Deafness, able or unable to talk
261-289	Other hearing impairments
300-319	Orthopedic impairment involving three or more limbs

320-339 Orthopedic impairment involving one upper and one
 lower limb (including side)

340, 341, 343 Orthopedic impairment involving one or both upper
350, 352, 354 limbs (including hands, fingers, and thumbs)—if
357, 359 both, and assistance of another person or devices
 is needed for activities of daily living

360, 361, 363 Orthopedic impairment involving one or both lower
370, 372, 374 limbs (including feet and toes)—if locomotion is
377, 379 impaired to a degree that bilateral upper limb
 assistance devices are required or individual is
 unable to utilize public buses or trains

355, 375, 395 Muscular dystrophy

356, 376, 396 Multiple sclerosis

358, 378, 398 Accidents and injuries involving the spinal cord

400-409 Loss of at least one upper and one lower extremity
 (including hands, thumbs, and feet)

410-419 Loss of both major upper extremities (including
 hands or thumbs)

430-439 Loss of one or both major lower extremities if bilateral
 at the ankle or above, or if one at mid-thigh that
 requires bilateral upper limb assistance devices, or
 individual is unable to utilize public buses or trains

500 Psychotic disorders

 If now requiring institutional care in a mental hospital
 or psychiatric ward of a general hospital; or has history
 of being institutionalized for treatment for three months

or more, or on multiple occasions; or meets the description for moderate or severe....

Mild:

Minor distortions of thinking with little or no disturbances in activities of daily living. With provision of rehabilitation services, can maintain independent living in the community and engage in competitive employment. Able to accept direction, maintain adequate interpersonal relations and concentrate sufficiently to perform job requirements. Only under occasional conditions of particular internal, social or economic stress, may require follow-up supervision, guidance or support. Includes one-time, short-term institutional discharges doing well on medication.

Moderate:

Definite disturbances of thinking with definite but mild disturbances in behavior. Includes hospital discharges who require daily medication to avoid rehospitalization. With provision of rehabilitation services, capable of maintaining themselves in the community and of engaging in low-stress competitive employment, but at least initially requiring continuing supervision, guidance, motivation and support. Misunderstanding of instructions, activity, self-isolation, or over-reaction in gesture, speech or emotion may be displayed during the

VR process and may cause concern to people in the work milieu.

Severe:

(a) Severe disturbances of thinking and behavior that entail potential harm to self or others; (b) or, in the extreme, severe disturbances of all components of daily living, requiring constant supervision and care. Persons in (a) with the provision of rehabilitation services may be capable of maintaining themselves in the community and to engage in limited or sporadic productive activity only under continuing supervision in shelter or protective environment, including halfway houses. They are unable to communicate readily and have difficulty differentiating between their fantasies and reality. Their behavior is disruptive and often menacing to others, marked by shouting, vulgarity, carelessness of dress and excretory functions. These symptoms and possible suicidal attempts necessitate continuing observation, professional intervention and medication, especially during early stages of the rehabilitation process.

510

Psychoneurotic disorders

if now requiring institutional care in a mental hospital or psychiatric ward of a general hospital or has history of being institutionalized for treatment for three months or more, or on

multiple occasions; or meets the description of moderate or severe....

Mild:

Stress reactions to daily living without substantial loss of personal or social efficiency. With the provision of rehabilitation services, can maintain independent living in the community and engage in competitive employment. Can accept direction, maintain adequate interpersonal relations and concentrate sufficiently to perform job requirements. Only under occasional conditions of particular internal, social or economic stress will require supervision, guidance and support after placement.

Moderate:

Stress reactions which modify patterns of daily living. Can maintain themselves in the community and perform adequately in low-stress competitive employment with the provision of rehabilitation services. May require medication and continuing supervision, motivation and support at least during early post-placement. Their fears, indecision, loss of interest or occasional odd behavior will be evident during the rehabilitation process, and may moderately interfere with job

performance and other worker's activities in employment when stressful situations arise.

Severe:

Stress reactions to daily living that result in continuing regression and tissue-organ pathology. Capable of productive work but only under sheltered, non-competitive, conditions in a highly structured or protective environment, at least initially. May require continuing medication. Bizarre and disruptive behavior, loss of interest in activities of daily living, problems with memory and concentration will be evident in the counseling process. These symptoms and the client's interference with other workers necessitates continuing supervision, guidance, motivation and support by professional staff in the work situation. Conversion reactions, poor eating and cleanliness habits may create considerable health problems.

532, 534

Moderate (I.Q. 54-40); severe (I.Q. 39-25).

Persons with FSIQ's in the mild (I.Q. 75-55) range who meet the criteria of S.D. by functional limitations (VRPM (3005.03 (43) #4), should be served in the Order of Selection Priority Category I and coded on the R-300B as 532. Those MR individuals, determined eligible, but who do not meet S.D. criteria should be coded 530 and served appropriately in the Order of Selection.

600 Colostomies resulting from malignant neoplasms
 601 Laryngectomies resulting from malignant neoplasms
 602 Leukemia and aleukemia
 616 Cystic fibrosis
 620 Hemophilia
 621 Sickle cell anemia
 630 Epilepsy--if not seizure-free for two years
 640-644 Heart conditions--if classified 2C or worse in the
 New York Heart Association Classification as
 adopted by the American Heart Association.
 651-654, 659 Respiratory system conditions--if maximum breath
 capacity is less than 55 percent of predicted or
 shortness of breath on climbing one flight of
 stairs or walking 100 yards on the level.
 664 Colostomies (from other than malignant neoplasms)
 671 End-stage renal failure
 680 Cleft palate and harelip with speech imperfections
 684 Laryngectomies (from other than malignant
 neoplasms)
 685 Aphasia resulting from intracranial hemorrhage,
 embolism, or thrombosis (stroke).
 (3005.03 [44 a through e])

APPENDIX C

DEFINITIONS OF TERMS

DEFINITIONS OF TERMS

Counselor Bias

This denotes the counselors' maintenance of beliefs about and expectations for, as well as provision of services to, clients due to the counselors' stereotypic beliefs (conventional beliefs regarding clients due to the clients' gender, race, and/or severity of disability classification rather than accepting them as individuals with characteristics unique to themselves).

Counselor Creaming

This denotes the practice of serving only those clients with the greatest and easiest potential for rehabilitation in order to create statistics that look good for the counselor and agency.

Counselor's Evaluation of Preparatory Services

When a client progresses in the rehabilitation process to the point that preparatory services have been completed, an assessment of the client's employability is made. This R-11 (contact report and case memorandum form) should reflect the following: a summary of the services that were provided including similar benefits (services which were not purchased by Rehabilitation Services); a statement explaining how these services contributed to the client's employability or employment; plans for placement if the client is not employed; information as to the employer, job duties, pay rate, how the job was secured and the counselor's role in job procurement if the client is

employed; and identification of all outstanding encumbrances and plans for clearing any open accounts. (VRPM 1509.10)

Dictionary of Occupational Titles (D.O.T.)

This is a listing of 20,000 definitions of occupations by a 9-digit occupational code. In the D.O.T. occupational classification system, each set of three digits in the 9-digit code number has a specific purpose or meaning. Together, they provide a unique identification code for a particular occupation which differentiates it from all others. The first three digits identify a particular occupational group. All occupations are clustered into one of nine broad categories (first digit). These are as follows:

- 0/1 Professional, Technical, and Managerial Occupations
- 2 Clerical and Sales Occupations
- 3 Service Occupations
- 4 Agricultural, Fishery, Forestry, and Related
Occupations
- 5 Processing Occupations
- 6 Machine Trades Occupations
- 7 Bench Work Occupations
- 8 Structural Work Occupations

These categories break down into 82 divisions (first 2 digits) and 559 homogeneous groups (first 3 digits). The middle three digits of the D.O.T. are worker function ratings based on data (fourth digit), people, (fifth digit), and things (sixth digit).

<u>Data</u>	<u>People</u>	<u>Things</u>
0 Synthesizing	0 Mentoring	0 Setting Up
1 Coordinating	1 Negotiating	1 Precision Working
2 Analyzing	2 Instructing	2 Operating--
3 Compiling	3 Supervising	Controlling
4 Computing	4 Diverting	3 Driving--
5 Copying	5 Persuading	Operating
6 Comparing	6 Speaking--	4 Manipulating
	Signaling	5 Tending
	7 Serving	6 Feeding--
	8 Taking	Offbearing
	Instructions--	7 Handling
	Helping	

Worker functions involving more complex responsibility and judgment are assigned lower numbers in these three lists while functions which are less complicated have higher numbers.

The last three digits indicate the alphabetical order of titles within 6-digit code groups. They serve to differentiate a particular occupation from all others. A number of occupations may have the same first six digits, but no two can have the same nine digits. If a 6-digit code is applicable to only one occupational title, the final three digits assigned are always 010. If there is more than one occupation with the same first six digits, the final three digits are usually assigned in alphabetical order of titles in multiples of four (010, 014, 018, 002, etc.). (D.O.T., pp. xvi--xviii)

Homemaker

This refers to a person (male or female) whose principal activity is keeping house for his/her family (VRPM 3005.03-32). The difference between self care and homemaker is that "the former relates to direct physical needs such as hygiene, dressing and mobility, while the latter is concerned with maintaining a suitable living environment" (VRPM 1541.18).

Individualized Written Rehabilitation Program (IWRP)

This is a written agreement between the counselor and the client formalizing the case planning and management practice of setting goals and objectives as well as the means and time frames for achieving them. The agreement is also designed to assure client participation and understanding as well as to protect the client's rights (VRPM 1502.17, also, see Appendix A for a copy of the form).

Major or Primary Disabling Condition

This is the diagnosis of the physical or mental condition that contributes the most to the individual's employment handicap (VRPM 3005.03[-26]).

Physical Restoration

This involves the medical and psychotherapeutic services that are necessary to determine the individual's rehabilitation potential and/or to enable the client to achieve his/her vocational goal.

"The Vocational Rehabilitation program does not have the legal responsibility for furnishing general medical services to the general population. Its responsibility is to a relatively small proportion of the population

in whom physical or mental disability has resulted in a substantial employment handicap and for whom there is a reasonable expectation of achieving employability." (VRPM 1513.01)

The division is not primarily concerned with medical services because they will prolong life, prevent premature death, alleviate pain or reduce or prevent disease unless employability is involved. For the purpose of this study, physical restoration will include medical and psychological services provided to a client to maximize his/her physical or mental functioning.

R-300 Master Client Record

The four forms (A, B, C, and D) are used to accumulate basic information pertaining to each individual in the rehabilitation process. The computerized statistical client data base stores the information input through the R-300 system. This information is to

- (1) measure the effectiveness of the rehabilitation program as a whole or by target groups at the State or National level;
- (2) to describe clients' characteristics and program-related experiences to Congress, State legislatures and various public and private organizations; and
- (3) to provide specific answers to questions which are frequently raised for budgetary, legislative, administrative and informational purposes" (VRPM 1502.16).

R-300-A is completed when the case is initially reported (at referral or at application).

R-300-B is completed at the completion of the referral process (the client is accepted or rejected for rehabilitation services).

R-300-C is completed at case closure (other than initial rejection).

R-300-D is completed when a case previously closed in Status 26 has been provided post employment services to help the individual maintain employment. (See Appendix G for copies of these forms.)

Severely Disabled (SD)

This denotes those individuals who received Social Security benefits or Supplemental Security Income based on their disabilities at any time during their rehabilitation process or met specific disability codes or criteria of functional limitations. (See Appendix B for a copy of Tennessee's criteria, VRPM 3005.03-43to48.)

Sheltered Employee

Goodwill Industries Policy and Procedure Manual (Revised 1984) provides the following definition:

An hourly employee whose wages are under the judicial of Wage and Hour regulations of the U.S. Department of Labor. This person is employed by a sheltered workshop setting because of some limiting handicap that prevents the individual from competing for regular employment at that time. A professional staff person monitors his progress with semi-annual performance reports. Direct supervision is provided by regular staff.

Status 26

This classification represents a client's successful rehabilitation. The individual must have been, as a minimum:

- (1) provided an evaluation of rehabilitation potential, and counseling and guidance (as a service directed toward job seeking strategies and development of job leads that resulted in job procurement) as essential vocational rehabilitation services,
- (2) provided appropriate vocational rehabilitation services in accordance with the Individualized Written Rehabilitation Program, or amendments thereto, and
- (3) determined to have achieved a suitable employment objective which has been maintained for a period of not less than sixty days" (VRPM 1549.06).

In some cases, however, a non-competitive occupation such as sheltered employment, homemaking or unpaid family worker may be the most appropriate vocational objective. Where a non-competitive occupation appears most suitable, the case record should indicate that all of the following criteria are met:

- (1) Substantial services can be provided which will materially contribute to an improvement in the client's adjustment or ability to function in the non-competitive occupation,
- (2) it is anticipated that the improved level of functioning will enable the client to make a significant contribution by participating in work activities in the sheltered, home, or family situation; and
- (3) as a result of the improved level of function and the work activity performed, socio-economic benefits may be realized" (VRPM 1541.10).

Unpaid Family Worker

The individual works without pay on a family farm or in a family business operated by one or more members of his/her own family (VRPM 3005.03-32).

Vocational Objective

This is the client's stated occupational goal. It is the basis for the program and the content of the program should relate to the achievement of the objective.

Vocational Training

This consists of any organized form of instruction which provides knowledge and skills that are essential for performing the tasks involved in an occupation. Such knowledge and skills may be acquired through training in an institution, on the job, by correspondence, by tutors or through a combination of these methods. It may be given for any occupation: semi-professional, professional, technical, clerical, agricultural, or for any of the skilled or semi-skilled trades.

VRPM

These initials stand for "Vocational Rehabilitation Program Manual" which is the agency's official policy manual.

APPENDIX D

SKILL OBJECTIVES FOR THE HOMEMAKER CHECKLIST

SKILL OBJECTIVES FOR THE HOMEMAKER CHECKLIST

Menu

Condition: Given the instruction, "Write a menu for the next seven days for all your meals."

Behavior: Client writes a menu for the week.

Standard: Behavior within one hour. Each day's menu must include the minimum daily requirements of the four basic food groups, according to nutritional standards (such as dietary council, U.S.D.A.).

Grocery List

Condition: Given a planned menu for the week's meals consisting of at least 10 different foods, and some of those foods in the home.

Behavior: Client makes a grocery list of the needed foods.

Standard: Behavior within 30 minutes. The grocery list must include at least the needed foods.

Shopping

Condition: Given a grocery list of at least 10 different foods, a grocery store, and a grocery cart.

Behavior: Client locates the foods on the list and places them in the cart.

Standard: Behavior within one hour. All foods on the list must be found (unless out of stock). No food must be damaged (eggs broken, bread mashed).

Meal Preparation

- Condition: Given a three-ounce box of gelatin dessert mix and access to their own kitchen or food preparation area with functional basic equipment.
- Behavior: Client prepares mix according to directions.
- Standard: Behavior within 20 minutes. Gelatin is all dissolved, well mixed, and product in refrigerator.

Dishwashing

- Condition: Given a minimum of two sets of dinner plates, silverware, glasses or cups and a minimum of three serving dishes and pans, all dirty (from preparing and eating food), a sink with hot soapy water, a dish rag, and a dish drainer.
- Behavior: Client places the dishes in the water, washes them, rinses them in warm water, and places them in the dish drainer.
- Standard: Behavior within 30 minutes. All food and soap must be washed from each dish.

Unmade Bed

- Condition: Given an unmade bed that has been slept in, or a bed that needs a change of linen (and clean linen).
- Behavior: Client makes the bed.
- Standard: Behavior within 10 minutes. Each corner of the bottom sheet must be tucked under each corner of the mattress. The top sheet must have two corners at the "foot" of the bed tucked under the two corners of the mattress. The other two sheet corners must be pulled up to lay directly on top of the two

corners of the mattress at the "head" of the bed. Any blanket or bedspread must be laid on top of the top sheet, wrinkle free.

Clothes Sorting

Condition: Given a pile of dirty clothes with at least 5 white and at least 5 articles of various colors.

Behavior: Client sorts into two categories (white and colored).

Standard: Behavior within 5 minutes. All white clothing must be in one pile and all colored clothing must be in the other pile.

Washer

Condition: Given a pile of dirty clothes (at least 5), all of which can be washed together, and either a coin-operated or home automatic washing machine.

Behavior: Client places clothes and soap into washer and operates washing machine.

Standard: Behavior within 10 minutes (for starting the machine). The clothes and soap must be added and the machine operated according to the laundromat's or the machine manufacturer's instructions.

Dryer

Condition: Given a load of clean, wet clothes, ready to be dried, and a coin-operated or home automatic dryer.

Behavior: Client places the clothes in the dryer and operates the machine.

Standard: Behavior within 10 minutes (for starting the machine). The clothes must be added and the machine operated according to the laundromat's or the machine manufacturer's instructions. When the clothes are removed they must be dry to the touch.

Dirty Kitchen

Condition: Given a kitchen containing a sink, stove, oven, refrigerator, and cleaning implements (such as sponge, rag, household cleaner, oven cleaner).

Behavior: Client cleans kitchen appliances and fixtures.

Standard: Behavior within one hour. No dirt spots or streaks must be visible on the sink, stove, oven, or refrigerator.

Child Dressing

Condition: Given an unclothed child and a shirt (with buttons), a pair of pants (with zipper), underpants, a pair of socks, and a pair of shoes (with shoelaces), all of the correct size.

Behavior: Client will put the clothes on the child.

Standard: Behavior within 10 minutes. Clothes must be put on and buttoned, zipped, and tied correctly.

Mending

Condition: Given an article of clothing with a tear or separated seam, and a threaded needle.

Behavior: Client mends the tear or separation.

Standard: Behavior within 30 minutes. The mend must remain closed, and no skin or undergarment must show through when the article is worn. (Gurthrie, Crist, Sienicki and Walls, 1981, pp. 93-94)

APPENDIX E

CLIENT QUESTIONNAIRE

Please enter the number for the term that best describes your opinion of the rehabilitation services you received.

4	3	2	1	0
Very	Generally	Generally	Very	Did Not
Pleased	Pleased	Displeased	Displeased	Receive

1. I was satisfied

with the services

I received from the

Rehabilitation

Services Counselor.	4	3	2	1	0
---------------------	---	---	---	---	---

I was satisfied

with the following

services I received

through Rehabilitation

Services:

2. Evaluation	4	3	2	1	0
3. Training	4	3	2	1	0
4. Counseling	4	3	2	1	0
5. Medical Care	4	3	2	1	0
6. Prosthesis	4	3	2	1	0
7. Work Adjustment	4	3	2	1	0
8. Job Placement	4	3	2	1	0

	0	1	2	3	4
	Never	Occassion- ally	Some- times	Most of the time	Always
9. My individual needs and goals were met.	0	1	2	3	4
10. The services I received were the ones I needed.	0	1	2	3	4
11. I had a say in my program of services.	0	1	2	3	4
12. My counselor accepted me for myself instead of letting my race or sex influence the services I received.	0	1	2	3	4

	Yes	No
13. I obtained the type of job I wanted.	1	0
14. I obtained the job for which I was qualified.	1	0
15. The rehabilitation services I received enabled me to become employed.	1	0
16. Please provide any suggestions you have for improving services to clients in the future.		
17. Please add any other comments you wish to make.		

APPENDIX F

STAFF QUESTIONNAIRE

TENNESSE DIVISION OF REHABILITATION SERVICES COUNSELORS:

This is a request for your participation in a study of the services provided by Rehabilitation Services to clients rehabilitated in fiscal year 1984. I am a rehabilitation counselor in Region 2A as well as a doctoral student at the University of Tennessee. Assistant Commissioner Sherry Harrison has reviewed the proposal and supports the study. She expressed interest in the overall results and conclusions of the study.

The purpose of the study is to determine how rehabilitation services have been provided in the past and how we can enhance future service delivery. Your help is needed to complete this study.

Your participation is voluntary. Refusal to participate will involve no penalty. I will not send you any follow-up letter if you do not participate. However, I would appreciate your taking the time to complete the questionnaire. Completion of the questionnaire will indicate your permission to use the data in the study.

Do not sign the form. As you may note, I have no place on the form for your name, district number or other identifying information. The envelope has my home address rather than the Region 2A office. This is done to maintain confidentiality for your responses. I believe you have strong opinions regarding these questions and I would like your honest answers.

I have no intention of giving any individual counselor's responses to central office. However, all the data will be compiled and summary information will be used for recommendations for future program planning.

When you have completed the questionnaire, please place it in the enclosed stamped self-addressed envelope and mail it. Thank you for your assistance.

If you have any question or comments, please contact me, Sally Wise, at 615-546-1530 (network 240-9301). My home address is 5700 Pleasant Ridge, #511, Knoxville, Tennessee 37912.

Please circle the number for the terms below that best describe your opinion of the rehabilitation process.

Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

1. It is better utilization of 0 1 2 3 4
time and funds to serve many
short-term clients than
clients with multiple
service needs.
2. Clients are placed in a few 0 1 2 3 4
main training categories (1
year or less) in order to
obtain quick Status 26
closures.
3. Occupational goals (IWRP) are 0 1 2 3 4
changed after services have
been provided in order to get
a Status 26 closure.
4. It is generally more 0 1 2 3 4
important that counselors
meet the Status 26 quota
than meet the individual
needs of each client.

Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

- | | | | | | | |
|----|------------------------------|---|---|---|---|---|
| 5. | Cases are closed due to the | 0 | 1 | 2 | 3 | 4 |
| | quota requirements rather | | | | | |
| | than because all appropriate | | | | | |
| | services have been provided. | | | | | |
| 6. | Cases are closed due to the | 0 | 1 | 2 | 3 | 4 |
| | quota for Status 26 | | | | | |
| | requirements rather than | | | | | |
| | because the client is | | | | | |
| | appropriately employed in | | | | | |
| | his/her chosen occupation. | | | | | |
| 7. | Women are often closed as | 0 | 1 | 2 | 3 | 4 |
| | homemakers rather than being | | | | | |
| | employed outside the home | | | | | |
| | due to the need for Status | | | | | |
| | 26 closures. | | | | | |
| 8. | Applications are rejected | 0 | 1 | 2 | 3 | 4 |
| | for service because the | | | | | |
| | client expenditures would | | | | | |
| | be high (such as cardiac | | | | | |
| | cases) and counselors | | | | | |
| | need to budget | | | | | |
| | allotments carefully. | | | | | |

Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

- | | | | | | | |
|-----|---|---|---|---|---|---|
| 9. | It is better utilization
of public funds to serve
many short-term clients
than to try to reduce SSI
and/or SSDI roles. | 0 | 1 | 2 | 3 | 4 |
| 10. | Men have a greater need for
more specialized training
than women do. | 0 | 1 | 2 | 3 | 4 |
| 11. | Women clients usually
prefer being homemakers to
working outside the home. | 0 | 1 | 2 | 3 | 4 |
| 12. | Men clients need to earn a
higher income at closure
than women do since men
have family financial
responsibilities. | 0 | 1 | 2 | 3 | 4 |
| 13. | Clients are likely to be
placed in a few main job
categories (waitress, sales
clerk, etc.,) since this
is a quick way to meet
the quota for Status 26
closures. | 0 | 1 | 2 | 3 | 4 |

Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

14. Unemployed clients are 0 1 2 3 4
closed as unpaid domestic
help, unpaid family
workers, homemakers,
etc., to obtain Status
26 closures when jobs
cannot be found for
them.
15. More short-term services 0 1 2 3 4
(less than 1 year) are
provided than long-term
services in order to reach
the quota for Status 26
closures.
16. It is a major duty of 0 1 2 3 4
Rehabilitation Services
to reduce SSI and SSDI
roles by helping these
clients become employed.
17. Clients already receiving 0 1 2 3 4
SSI and SSDI are less
motivated to become
rehabilitated than are
other clients.

Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

- | | | | | | | |
|-----|--|---|---|---|---|---|
| 18. | Black clients are less
interested in training
than white clients are. | 0 | 1 | 2 | 3 | 4 |
| 19. | Black clients are less
likely to benefit from
training than white
clients are. | 0 | 1 | 2 | 3 | 4 |
| 20. | Training should be avoided
whenever possible in order
to speed up the
rehabilitation process. | 0 | 1 | 2 | 3 | 4 |
| 21. | Short term physical
restoration services are
the most appropriate
use of funds. | 0 | 1 | 2 | 3 | 4 |
| 22. | Serving the severely
disabled is the primary
function of Rehabilitation
Services counselors. | 0 | 1 | 2 | 3 | 4 |
| 23. | Many severely disabled
clients can be more
effectively rehabilitated
by being trained to work
at home. | 0 | 1 | 2 | 3 | 4 |

Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

24. Women are generally less 0 1 2 3 4

interested in training

than men are.

25. Ineligible clients are 0 1 2 3 4

served if they can be

quickly closed in Status

26.

26. More effective services 0 1 2 3 4

would be provided if

counselors did not have

to worry about meeting

the quota for Status 26

closures.

27. The present quota system 0 1 2 3 4

is the best method of

determining the value of

rehabilitation services.

28. "Creative writing" may be 0 1 2 3 4

necessary in order to reach

the quota for Status 26

closures.

Please mark whether you agree or disagree that the following suggestions would improve the rehabilitation process:

Disagree = 0

Agree = 1

- | | | |
|--|---|---|
| 29. Following the manual exactly
rather than having to justify
past expenditures. | 0 | 1 |
| 30. Doing minimal diagnostic
evaluation to determine
feasibility. | 0 | 1 |
| 31. Reducing "band-aid therapy",
thus avoiding reapplication. | 0 | 1 |
| 32. Providing the fewest services
necessary to rehabilitate clients. | 0 | 1 |
| 33. Establishing homemakers/unpaid
family workers as a separate
program from the vocational
rehabilitation program. | 0 | 1 |
| 34. Separating independent living
skills programs from the
vocational rehabilitation
program. | 0 | 1 |
| 35. Including more counseling
courses in Rehabilitation
Services counselor training
programs. | 0 | 1 |

Disagree = 0

Agree = 1

- | | | |
|--|---|---|
| 36. Teaching clients self-reliance. | 0 | 1 |
| 37. Providing skills for clients to become able to obtain their own employment (i.e., "Give a man a fish and you feed him for a meal, teach him to fish and you feed him for a lifetime"). | 0 | 1 |
| 38. Emphasizing serving severely disabled clients rather than concentrating on quick Status 26 closures. | 0 | 1 |
| 39. Increasing opportunities for clients to have input into their programs. | 0 | 1 |
| 40. Increasing opportunities for clients to have input into the Rehabilitation Services program in general (such as a client advisory board or clients evaluating their program at closure). | 0 | 1 |

Disagree = 0

Agree = 1

- | | | |
|--|---|---|
| 41. Serving the client from a
wholistic approach rather
than concentrating on only
the most limiting aspect
of the disability. | 0 | 1 |
| 42. Providing minimal maintenance
payments to avoid creating
client dependency on unstable
funding. | 0 | 1 |
| 43. Increasing the number of
employer representatives. | 0 | 1 |
| 44. Improving relations with
referral agencies to reduce
inappropriate referrals. | 0 | 1 |
| 45. Increasing public education
programs regarding
Rehabilitation Services and
resulting benefits to the
community. | 0 | 1 |

APPENDIX G

R-300 MASTER CLIENT RECORD

CLIENT MASTER RECORD
REFERRAL AND APPLICANT STATUS
PART 1

District No.

Client No.

A. Client

Name Last First Initial Address Number and Street

City County County Code

State Zip Code

B. Disability

As Reported Code

C. Referral Date

(Status 00)

D. Referral Source (Circle appropriate code below)

- Codes Description
- (1.) Educational Institutions
- 10 College or University (institution offering higher than secondary education, including junior colleges)
- 12 Vocational school (including business, trade, and other technical; (public and private)
- 14 Elementary or High School (public and private)
- 16 School for the physically or mentally handicapped (public and private)
- 19 Other educational institution
- (2.) Hospitals and Sanatoriums
- 20 Mental Hospitals (public and private)
- 22 Other chronic condition or specialized, hospital or sanatorium (public and private)
- 24 General Hospital (public and private)
- 29 Other hospital or clinic, n.e.c. (except public health clinic)
- (3.) Health Organizations and Agencies
- 30 Rehabilitation facility (except Community Mental Health Center)
- 32 Community Mental Health Center
- 34 State Crippled Childrens Agency
- 38 Other Public Health Department, organization, or agency (including public health nurse or clinic)
- 39 Other private health organization or agency

- Codes Description
- (4.) Welfare Agencies
- 40 Public Welfare Agency (State and Local Government)
- 44 Private Welfare Agency (including Labor Union Welfare Fund and Civic or Community Welfare Organization)
- (5.) Public Organizations and Agencies not specifically educational, health, or welfare
- 50 Social Security Disability Determination Unit
- 51 Social Security District Office
- 52 Workmen's Compensation Agency (Federal and State)
- 53 State Employment Service
- 54 Selective Service System
- 55 State Vocational Rehabilitation Agency
- 56 Correctional Institution, Court, or Officer (Federal, State, and Local)
- 58 Retirement Program (State & Local Government)
- 59 Other Public Organization or Agency (including public official not representing above organizations or agencies)
- (6.) Private Organization and Agencies (not specifically educational, health, or welfare)
- 60 Artificial Appliance Company
- 62 Employer (Private)
- 69 Other private organization or agency
- (7.) Individuals
- 70 Self-Referral Person
- 72 Physician, NEC
- 79 Other individual, NEC

E. Age at Referral

Birth Date

F. Status at Referral

- SSDI SSI
- 0 0 Not an applicant
- 1 1 Applicant - Allowed benefits
- 2 2 Applicant - Denied Benefits
- 3 3 Applicant - Status of application pending
- 4 4 Not known if an applicant
- 5 5 Benefits discontinued or terminated

G. Race

- 1 White
- 2 Black
- 3 American Indian or Alaskan Native
- 4 Asian or Pacific Islander
- 5 Not Available

H. Sex

- 1 Male
- 2 Female

I. Social Security No.

J. Date Application Signed (Status 00)

Counselor Signature Date

ED-2191

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES

CLIENT MASTER RECORD
REFERRAL PROCESS COMPLETED

District No. _____ Client No. _____ Client Name Last First Initial _____

A Date Referral Process Completed _____

B Date Plan Completed (Status 02) _____

C Social Security No. _____

D SSDI/SSI Status at Referral

0	Not an applicant
1	Applicant - All other benefits
2	Applicant - Denied Benefits
3	Applicant - Status of application pending
4	Not known if an applicant (Do not use if accepted for extended evaluation or VR services)
5	Benefits discontinued or terminated

E Race

1	White
2	Black
3	American Indian or Alaskan Native
4	Asian or Pacific Islander
Y	Not Available

F Hispanic Origin Yes ☐ No ☐

G Outcome of Referral Process

Closed From _____ Closed From _____

Status 00 _____ Status 02 _____

Reason Closed

1	Unable to locate or contact or moved
2	Hadn't had too severe or unfavorable medical prognosis
3	Refused services or further services
4	Death
5	Client institutionalized
6	Transfer to another agency
7	Failure to cooperate
8	No disabling condition
9	No vocational handicap
Y	Other

24) _____ Accepted 18 mos. Ext. Eval. (06)

25) _____ Accepted for VR services (10)

H Disabling Conditions (describe)

1 Major _____ Code _____

2 Secondary _____ Code _____

I Previous Closure within 36 months

Not _____ Yes Outcome Rehab _____ 2 Not Rehab _____ 3

If Yes: Months from last closure Date to current Referral Date _____

J Marital Status

1	Married	4	Separated
2	Widowed	5	Never married
3	Divorced	Y	Not available

K Number of Dependents - 0 1 2 3 4 5 6 7 8 9 or more

L Total Number in Family - 1 2 3 4 5 6 7 8 9 or more

M Highest grade of school completed _____ (M-R = 1-12)

N Work Status

1	Wage earner (paid or unpaid) competitive labor market
2	Wage or salaried worker - sheltered workshop
3	Self-employed (except BEP)
4	State agency managed business enterprise (BEP)
5	Homemaker
6	Unpaid family worker
7	Not working - student
8	Not working - other
9	Training or worker (noncompetitive labor market)
Y	Not available

O Weekly Earnings (nearest \$) \$ _____ None _____ 000

P Total Monthly Family Income

0	\$ 0.00-149.99	6	\$400.00-449.99
1	\$150.00-199.99	7	\$450.00-499.99
2	\$200.00-249.99	8	\$500.00-599.99
3	\$250.00-299.99	9	\$600.00 and over
4	\$300.00-349.99	Y	Not available
5	\$350.00-399.99		

Q Type Public Assistance

0	None
1	CAF - Aged
2	CAF - Blind
3	CAF - Disabled
4	Adult Families with Dependent Children only (AFDC)
5	General Assistance only (GA)
6	AFIN and SSI in Combination
7	Type not known
Y	Not available (Do not use if accepted for extended evaluation or VR services)

R P.A. Monthly Amount (nearest \$) \$ _____ None _____ 000

S Time on Public Assistance

0	Not receiving public assistance	5	Three years but less than four
1	Less than six months	6	Four years but less than five
2	Six months but less than one year	7	Five years or more
3	One year but less than two	Y	Not Available
4	Two years but less than three		

T Primary Source of Support

00	Current earnings, interest, dividends, rent
01	Family and friends
02	Private relief agency
03	Public Assistance, at least partly with Federal funds
04	Public assistance, without Federal funds (General Assistance only)
05	Public institution - fee supported
06	Workmen's compensation
07	Social Security Disability Insurance benefits
08	All other public sources
09	Annuity or other non-disability insurance benefits (private insurance)
10	All other sources of support
Y Y	Not Available

U Type of Institution of Referral

00	Not in institution at referral
01	Public mental hospital
02	Private mental hospital
03	Psychiatric inpatient of general hospital
04	Community mental health center inpatient
05	Public institution for mentally retarded
06	Private institution for mentally retarded
07	Alcoholism treatment center
08	Drug abuse treatment center
09	School and other institution for the blind
10	School and other institution for the deaf
11	General hospital
12	Hospital or specialized facility for chronic illness
13	Institution for the aged
14	Maltreat home
15	Correctional institution - adult
16	Correctional institution - juvenile
17	Other institutions and special living arrangements including group homes

V Federal Special Program Identification

None	VE	VET	IDR	MAW	PO	WIN	IBE	SP	SO	None

State Special Program Identification

None	SOA	CP								

W Referred by Social Security Administration ☐ No ☐ Yes

X Social Security Claim Type

1	DIB - Disabled wage earner
2	CDB - DA Claim for disabled child benefits based on account number of a retired or deceased wage earner
3	COB - DI Claim for disabled child benefits based on account number of wage earner currently entitled to disability benefits
4	DWB - Claim for disabled widow, widower, or surviving divorced wife benefits based on account number of a deceased wage earner
5	Survivor's - Dependents

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES

CLIENT MASTER RECORD
TO BE RECORDED AT TIME OF CLOSURE

PART 3

District No. Client No. Client Name Last First Initial

A. Federal Special Program Identification

None	TF	VET	IDR	MAW	PO	WIN	I&E	SF	SD	SUM
000	001	002	004	010	020	040	100	200	400	

State Special Program Identification

None	SGM	CP								SUM
000	001	002	004	010	020	040	100	200	400	

B. Referred by Social Security Administration

- 1 ☐ No
2 ☐ Yes

C. Status at Time of Closure

- SSDI SSI
0 0 Not an applicant
1 1 Applicant - Allowed benefits
2 2 Applicant - Denied Benefits
3 3 Applicant - Status of application pending
4 4 Not known if an applicant (Do not use if closed in status 26)
5 5 Benefits discontinued or terminated

D. Work Status

- 1 Wage or salaried worker - competitive labor market
2 Wage or salaried worker - sheltered workshop
3 Self-employed (except BEP)
4 State agency managed business enterprise (BEP)
5 Homemaker
6 Unpaid family worker

Do not use the Following Codes at Closure for Status 26 Closures

- 7 Not working - student
8 Not working - other
9 Trainee or worker (non-competitive labor market)
Y Not available

E. Weekly Earnings (Nearest \$ None 000
(Not Known=YYY)

F. Public Assistance

Type

- 0 None (Do not use if client received PA between referral and closure. See code 9)
1 SSI - Adult
2 SSI - Blind
3 SSI - Disabled
4 Aid to Families with Dependent Children only (AFDC)
5 General Assistance only (GA)
6 AFDC and SSI in Combination
8 Type(s) not known
9 PA received between referral and closure only. (Record dollar amount of first check)
Y Not available (Do not use if closed in status 26)

G. Monthly Amount

(Nearest \$) None 000

H. Occupation (title)

Code
(Not known=XXXX)

Counselor Signature

DATE

104-1061-1-1000-0

HS-1379

I. Outcome of Extended Evaluation or VR Services

- 1 ☐ Closed from Ext. Eval. (status 08) Reason
2 ☐ Closed Rehabilitated (status 26)
3 ☐ Closed Not Rehabilitated (status 28) Reason
4 ☐ Closed Not Rehabilitated (status 30) Reason

Reason for Closure

- 1 Unable to locate or contact; or moved
2 Handicap too severe or unfavorable medical prognosis
3 Refused services or further services
4 Death
5 Client institutionalized
6 Transfer to another agency
7 Failure to cooperate
Y Other

J. Services Provided: Indicate (x) if applicable

Type of Service Provided or Arranged for by Agency	Without COST
10 Diagnostic and Evaluation	
11 Restoration (Physical or Mental)	
12 T College or University	
13 R Other Academic (Elem. or HS)	
14 A Business School or College	
15 I Vocational School	
16 N On-the-Job	
17 N Personal and Voc. Adjustment	
18 G Miscellaneous	
19 Maintenance	
20 Other Services	
21 Services to other family members	

K. Social Security Claim Type

- 1 DIB Disabled wage earner
2 CDB-OA Claim for disabled child benefits based on account number of a retired or deceased wage earner
3 CDB-DI Claim for disabled child benefits based on account number of wage earner currently entitled to disability benefits
4 DWB Claim for disabled widow, widower, or surviving divorced wife benefits based on account number of a deceased wage earner
9 No trust fund expenditures

ED-2332

APPENDIX H

RESPONSES TO COUNSELOR QUESTIONNAIRES

Responses to the counselors' questionnaires are provided below.

They are reported by percentages. Rater responses are also presented showing how each rater scored the general response to the questions.

1. It is better utilization of time and funds to serve many short-term clients than clients with multiple service needs.

Never = 11%	Rater A = Bias
Rarely = 13%	Rater B = Bias
Sometimes = 34%	Rater C = Bias
Often = 33%	Rater D = Bias
Always = 9%	

2. Clients are placed in a few main training categories (1 year or less) in order to obtain quick Status 26 Closures.

Never = 20%	Rater A = Bias
Rarely = 36%	Rater B = Bias
Sometimes = 24%	Rater C = Bias
Often = 21%	Rater D = No Bias
Always = 0%	

3. Occupational goals (IWRP) are changed after services have been provided in order to get a Status 26 closure.

Never = 7%	Rater A = Bias
Rarely = 24%	Rater B = Bias
Sometimes = 48%	Rater C = Bias
Often = 20%	Rater D = Bias
Always = 1%	

4. It is generally more important that counselors meet the Status 26 quota than meet the individual needs of each client.

Never = 25%	Rater A = Bias
Rarely = 22%	Rater B = Bias
Sometimes = 13%	Rater C = Bias
Often = 24%	Rater D = Bias
Always = 16%	

5. Cases are closed due to the quota requirements rather than because all appropriate services have been provided.

Never = 25%	Rater A = Bias
Rarely = 25%	Rater B = Bias
Sometimes = 18%	Rater C = Bias
Often = 24%	Rater D = Bias
Always = 8%	

6. Cases are closed due to the quota for Status 26 requirements rather than because the client is appropriately employed in his/her chosen occupation.

Never = 17%	Rater A = Bias
Rarely = 26%	Rater B = Bias
Sometimes = 22%	Rater C = Bias
Often = 28%	Rater D = Bias
Always = 7%	

7. Women are often closed as homemakers rather than being employed outside the home due to the need for Status 26 closures.

Never = 28%	Rater A = Bias
Rarely = 37%	Rater B = Bias
Sometimes = 21%	Rater C = No Bias
Often = 11%	Rater D = No Bias
Always = 4%	

8. Applications are rejected for service because the client expenditures would be high (such as cardiac cases) and counselors need to budget allotments carefully.

Never = 25%	Rater A = Bias
Rarely = 29%	Rater B = Bias
Sometimes = 29%	Rater C = No Bias
Often = 13%	Rater D = No Bias
Always = 4%	

9. It is better utilization of public funds to serve many short-term clients than to try to reduce SSI and/or SSDI rolls.

Never = 18%	Rater A = Bias
Rarely = 21%	Rater B = Bias
Sometimes = 36%	Rater C = No Bias
Often = 18%	Rater D = Bias
Always = 7%	

10. Men have a greater need for more specialized training than women do.

Never = 38%	Rater A = Bias
Rarely = 35%	Rater B = Bias
Sometimes = 22%	Rater C = No Bias
Often = 5%	Rater D = No Bias
Always = 0%	

11. Women clients usually prefer being homemakers to working outside the home.

Never = 11%	Rater A = Bias
Rarely = 55%	Rater B = Bias
Sometimes = 23%	Rater C = No Bias
Often = 11%	Rater C = No Bias
Always = 0%	

12. Men clients need to earn a higher income at closure than women do since men have family financial responsibilities.

Never = 29%	Rater A = Bias
Rarely = 31%	Rater B = Bias
Sometimes = 29%	Rater C = No Bias
Often = 9%	Rater D = No Bias
Always = 1%	

13. Clients are more likely to be placed in a few main job categories (waitress, sales clerk, etc.) since this is a quick way to meet the quota for Status 26 closures.

Never = 20%	Rater A = Bias
Rarely = 28%	Rater B = Bias
Sometimes = 26%	Rater C = Bias
Often = 24%	Rater D = Bias
Always = 3%	

14. Unemployed clients are closed as unpaid domestic help, unpaid family workers, homemakers, etc., to obtain Status 26 closures when jobs cannot be found for them.

Never = 26%	Rater A = Bias
Rarely = 39%	Rater B = Bias
Sometimes = 20%	Rater C = Bias
Often = 11%	Rater D = No Bias
Always = 4%	

15. More short-term services (less than 1 year) are provided than long-term services in order to reach the quota for Status 26 closures.

Never = 17%	Rater A = Bias
Rarely = 25%	Rater B = Bias
Sometimes = 35%	Rater C = Bias
Often = 17%	Rater D = Bias
Always = 5%	

16. It is a major duty of Rehabilitation Services to reduce SSI and SSDI roles by helping these clients become employed.

Never = 1%	Rater A = Bias
Rarely = 8%	Rater B = Bias
Sometimes = 24%	Rater C = No Bias
Often = 27%	Rater D = No Bias
Always = 39%	

17. Clients already receiving SSI and SSDI are less motivated to become rehabilitated than are other clients.

Never = 0%	Rater A = Bias
Rarely = 3%	Rater B = Bias
Sometimes = 28%	Rater C = No Bias
Often = 45%	Rater D = Bias
Always = 25%	

18. Black clients are less interested in training than white clients are.

Never = 18%	Rater A = Bias
Rarely = 43%	Rater B = Bias
Sometimes = 22%	Rater C = No Bias
Often = 15%	Rater D = No Bias
Always = 1%	

19. Black clients are less likely to benefit from training than white clients are.

Never = 28%

Rater A = Bias

Rarely = 55%

Rater B = Bias

Sometimes = 12%

Rater C = No Bias

Often = 4%

Rater D = No Bias

Always = 0%

20. Training should be avoided whenever possible in order to speed up the rehabilitation process.

Never = 55%

Rater A = ?

Rarely = 33%

Rater B = Bias

Sometimes = 8%

Rater C = No Bias

Often = 3%

Rater D = No Bias

Always = 1%

21. Short-term physical restoration services are the most appropriate use of funds.

Never = 11%

Rater A = Bias

Rarely = 18%

Rater B = Bias

Sometimes = 49%

Rater C = No bias

Often = 17%

Rater D = Bias

Always = 5%

22. Serving the severely disabled is the primary function of Rehabilitation Services counselors.

Never = 1%	Rater A = Bias
Rarely = 9%	Rater B = Bias
Sometimes = 27%	Rater C = No Bias
Often = 35%	Rater D = No Bias
Always = 27%	

23. Many severely disabled clients can be more effectively rehabilitated by being trained to work at home.

Never = 3%	Rater A = Bias
Rarely = 39%	Rater B = Bias
Sometimes = 43%	Rater C = Bias
Often = 15%	Rater D = No Bias
Always = 1%	

24. Women are generally less interested in training than men are.

Never = 26%	Rater A = Bias
Rarely = 50%	Rater B = Bias
Sometimes = 18%	Rater C = No Bias
Often = 7%	Rater D = No Bias
Always = 0%	

25. Ineligible clients are served if they can be quickly closed
in Status 26.

Never = 56%	Rater A = Bias
Rarely = 21%	Rater B = Bias
Sometimes = 12%	Rater C = Bias
Often = 9%	Rater D = No Bias
Always = 1%	

26. More effective services would be provided if counselors
did not have to worry about meeting the quota for Status 26 closures.

Never = 11%	Rater A = Bias
Rarely = 9%	Rater B = Bias
Sometimes 16%	Rater C = No Bias
Often = 35%	Rater D = Bias
Always = 29%	

27. The present quota system is the best method of determining
the value of rehabilitation services.

Never = 24%	Rater A = Bias
Rarely = 30%	Rater B = No Bias
Sometimes = 31%	Rater C = No Bias
Often = 9%	Rater D = No Bias
Always = 5%	

28. "Creative writing" may be necessary in order to reach the quota for Status 26.

Never = 17%

Rater A = Bias

Rarely = 21%

Rater B = Bias

Sometimes = 33%

Rater C = Bias

Often = 27%

Rater D = Bias

Always = 1%

APPENDIX I

ORDER OF SELECTION PRIORITY CATEGORIES

The Order of Selection shall have priority categories as follows:

Priority Category 1

Eligible severely handicapped.

Priority Category 2

Eligible Public Safety Officers who are non-severely handicapped whose handicapping condition arose from a disability sustained in the line of duty.

Priority Category 3

Eligible non-severely handicapped clients for whom it is anticipated will not require purchased vocational rehabilitation services (counseling, guidance, placement, referral services, coordination of similar benefits, and/or third party payment).

Priority Category 4

Eligible non-severely handicapped clients who are to be provided services other than evaluation from an agency-operated facility or a program providing services under grant funds from the agency.

Priority Category 5

Eligible non-severely handicapped clients whose disability results in permanent functional limitation that will have a vocational objective of competitive employment.

Priority Category 6

Eligible non-severely handicapped clients that will have a vocational objective of competitive employment.

Priority Category 7

Eligible non-severely handicapped clients whose disability results in permanent functional limitations.

Priority Category 8

Eligible non-severely handicapped clients that cannot be classified into a higher priority category.

VITA

Sally Ann Wise was born in Columbia, Pennsylvania on August 13, 1947. She attended elementary schools primarily in Indianapolis, Indiana. She later moved to Portland, Tennessee. After graduation from Portland High School in 1965, she entered Cumberland College of Tennessee in Lebanon, Tennessee and received an Associate Arts degree in 1967. She obtained a Bachelor of Science degree in Education from Tennessee Technological University in 1969. She also obtained from that university a Master of Arts degree with a major in Educational Psychology and Guidance in 1974 and a Specialist in Education degree in Educational Psychology and Guidance in 1978.

While in graduate school, she has been employed by the State of Tennessee. She was a social counselor for the Department of Human Services from 1969 to 1975 when she was promoted to supervisor. She is currently employed by the Division of Rehabilitation Services.

The author is a member of Phi Kappa Phi. She has held professional membership in the National Association of Social Workers and the National Rehabilitation Association. Volunteer work includes Big Brothers/Big Sisters of Knoxville, Operation Health Check and the Dogwood Arts Festival. She is Chair of the Special Events Subcommittee of the Public Affairs Committee of the Department of Human Services.