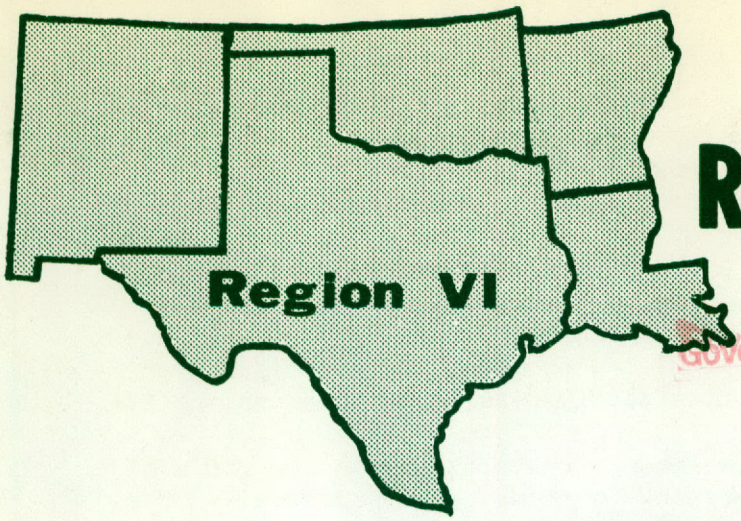

Research Review

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Difficulty Determination of Rehabilitation Services

The deficiencies of the present closure system are a source of concern and irritation to most people involved in vocational rehabilitation. The most often mentioned alternative to the present system has been a weighted case closure system in which weights are based on relative case difficulty. "Difficulty", however, has not been precisely defined. The question might be asked, "Difficulty for whom: the individual client, the counselor, the rehabilitation agency or other persons and agencies attempting to aid the client in the rehabilitation process?" If the goal of difficulty determination is to evaluate the individual counselor, then the counselor's effort is the focus of concern. If the goal is evaluation of the service delivery system, all components of that system are involved. If the question is raised to the social level, difficulty determination must include not only the delivery system itself, but also the effort expended by other groups, agencies and individuals.

Several investigators have attempted to operationalize difficulty in terms of probability of successful (status 26) closure as a criterion measure. An individual client can vary considerably in terms of "difficulty", depending on whether his vocational goal is competitive employment, sheltered employment, homemaker, or unpaid family worker, not to mention a host of other factors which contribute to difficulty. Since the 26 closure is used as a measure of "success" of the client, it is not surprising that previous research accomplished little in measuring the difficulty with which this "success" was achieved. The 26 closure status indicates very little about the client in terms of the utilization of his capabilities, his aspirations and the suitability of placement. It indicates even less about the "people process" and resources which helped bring the client to the point of "successful rehabilitation". As long as case difficulty is tied to the 26 closure system, little can be done to relieve the present evaluation problems that are hampering good rehabilitation practice.

It may prove extremely useful to become divorced from the concepts of closure and difficulty altogether and reexamine the requirements for a contempor-

ary method of program evaluation. As a starting point, it is necessary to distinguish between evaluating the effectiveness of a program and evaluating the efficiency of a program. These are essentially two different areas. Effectiveness of services involves the changes in the clients in reference to the goals of rehabilitation as a result of the rehabilitation process. Efficiency refers to the economical use of resources to produce these changes. It is, therefore, quite possible for a program to be very effective, while at the same time be inefficient. However, a program cannot be efficient unless it is effective. To adequately evaluate a program, it is necessary to first establish adequate measures of its effectiveness; only then can the efficiency of the program be measured.

To evaluate effectiveness, it is first necessary to establish the goals of the program. Effectiveness only has meaning in terms of program goals. The more specifically the goals are stated, the more accurate the evaluation can be. Within the framework of the goals of rehabilitation, it is then necessary to know:

(1). the client's status in terms of these goals at entry into the program,

(2). the client's status at closure,

(3). an index of client change, and

(4). the degree to which rehabilitation service contributed to the change in client status.

The first three items involve a direct assessment of the client in terms of the goals of rehabilitation, while the fourth usually involves the comparison of rehabilitation clients with similar non-clients.

A measure of the client's status at entry into the program gives information about the population being served. The target population for rehabilitation is the nation's disabled: however, the term "disabled" covers a wide range of client problems with varying degrees of severity. Simply classifying a client in terms of a medical diagnosis does not focus attention on the appropriate client attributes. The work of rehabilitation is centered around the functional abilities and limitations of the client. Therefore, type and severity of disability must be measured in the framework of the client's functional abilities. To determine if the program goals are being met and the intended target population is being served, information regarding the client's functional level must be obtained. Information of this type also provides a baseline for the measurement of change.

The client's status at closure should be measured by the same functional criteria that his status at entry was measured. This provides the information necessary to:

(1). determine whether the goals are being reached and

(2). allow for the development of a client change index.

These measures need to reflect changes in economic status and in vocational, educational and psychosocial functioning in order to adequately depict the outcome of the rehabilitation process.

Succinctly stated, client change is essentially the difference between the client's level of functioning at entry and the client's level of functioning

at closure. Since success and failure are not magical absolute qualities, it would be extremely valuable to know the amount of change and to be able to measure the varying degrees of success and failure. It is quite possible that clients benefit significantly from rehabilitative services without ever reaching the desired goal - that of a status 26 closure.

Only after the client's functional levels (at entrance and exit) and the change associated with them are established can the effect of rehabilitation services toward producing these changes be determined. This is the next essential step in assessing program effectiveness. The determination of the effect of program services in producing client change ideally involves the use of non-client control groups. This approach is not practical and necessitates ethical considerations. The control group situation will probably remain in the province of special studies rather than being a systematically-implemented method of program evaluation.

Most often, it is assumed that a program's services had a major effect in producing client change. Even without making this assumption (if the first three elements have been satisfactorily measured), it is possible to investigate differences in programs serving the same types of clients, increases or decreases in program effectiveness over a period of time and whether or not there has been client change produced by any source. Measurement of client status (at entry and closure) and client change does not solely satisfy the needs of program evaluation. It does, however, supply the essential prerequisites.

Given the measures discussed above, it becomes possible to evaluate the many variables that might be associated with client change. This evaluation may include assessment of client characteristics and treatment effects, as well as analysis of cost and administrative efficiency. In addition to making statements about present program efficiency, it is possible to more accurately estimate the effect of program changes and to determine whether the changes actually occurred after the program adjustments were implemented.

To relate the concept of case difficulty to the effectiveness measures discussed above, a distinction should be made between client difficulty and case difficulty. Client difficulty refers to the functional limitations of the client. These are problems the client must adjust to and live with, regardless of whether he receives vocational rehabilitation services. Case difficulty would include client difficulty, plus variables such as availability of transportation and appropriate rehabilitation facilities, money, medical technology and additional factors. In order to evaluate the counselor, many other variables besides client difficulty must be taken into consideration. It is highly unlikely that any number (whether it is the amount of case closures or weighted case closures) will be able to reflect by itself the quality of work done by the individual counselor. However, with adequate effectiveness measures, judgments can be made about the effect of services upon the client and, in turn, the sources of these rehabilitation efforts can be studied.

The previous summary was prepared for the Research Review by Lowell Lenhart and W. J. Westerheide of the Department of Institutions, Social and Rehabilitative Services, Oklahoma City, Oklahoma. Comments on the preceding material or requests for additional data should be sent to them and addressed to P. O. Box 25352, Oklahoma City, Oklahoma 73125.

(Readers might like to refer to Quality Measurement of VR Services which appeared in the Spring Edition - 1973 - of the Research Review and was written by the same authors).

Arkansas Project for the Multiply Handicapped Deaf

The five primary objectives of the Project for Multiply Handicapped Deaf Adults (Project Number 14-P-55216) conducted at the Hot Springs Rehabilitation Center, Hot Springs, Arkansas, from June 1, 1968 - May 31, 1973 were:

(1). to provide a setting for the investigation of severely handicapped deaf adults,

(2). to evaluate the effectiveness of the comprehensive rehabilitation facility in rehabilitating severely handicapped deaf adults,

(3). to investigate the consequences of regional facility programs for deaf adults,

(4). to develop a meaningful evaluation and service program for rehabilitating severely handicapped deaf adults, and

(5). to provide a setting for conducting internships, practicums and short-term training conferences for rehabilitation personnel who work with the deaf.

A total of 212 multiply handicapped deaf clients from 29 states, the District of Columbia and the Virgin Islands were enrolled in a program which generally offered the traditional rehabilitation services required by hearing individuals. Provisions for hiring special staff members who could effectively communicate with low (under) achieving deaf clients permitted intensive adjustment services, remedial and vocational tutoring, vocational evaluation, counseling and job skill training. Innovative or additional services implemented by Project staff included training for independent community living, driver's education, recreational activities and vocational evaluation utilizing work sample and psychological tests in combination with job tryouts.

The Project's sample population was predominantly male (70%) and varied from 16 - 25 years of age. Approximately 65% of the clients were from Arkansas or nearby states. With but few exceptions, the Project's clients were in the average range of intelligence, but were achieving at mid-third grade level academically. Special forms developed by Project staff for use by counselors, school personnel and parents provided the sources for collection of client data.

Significant findings for rehabilitation and social service workers are listed below:

(1). The Hot Springs Rehabilitation Center Project for Multiply Handicapped Deaf Adults (MHD) demonstrated that this subgroup of the deaf population can be successfully served within the framework of a comprehensive rehabilitation center.

(a). Multiply handicapped deaf rehabilitation clients have similar service needs as do disabled individuals who can hear. However, most MHD clients require extensive services of a preparatory

and "habilitative" nature.

(b). The service needs of MHD clients are more adequately met and served through specialized rehabilitation personnel who are aware of and alert to the limitations and unique problems of these individuals.

(c). MHD clients require intensive introduction and orientation prior to their participation in each service or service program at a comprehensive rehabilitation center.

(d). Advocates for the deaf client are needed in all phases of rehabilitation services if this particular disability group is to obtain maximum benefits.

(2). Comprehensive adjustment services (personal-social, remedial, educational and work) are vital components of the deaf client's program of rehabilitation due to frequent social, educational, personal and vocational immaturity and deprivation.

(a). The purposes and objectives of adjustment services must be explained to the client in a language he can comprehend.

(b). Student-staff ratio must be restricted to a reasonable level due to the MHD client's retarded communication/language ability, deficient academic skills, lack of acceptable work habits, etc.

(c). Work activities in work adjustment services must be meaningful to the deaf client. Busy work is not conducive to positive client gains.

(d). Systematic and well-planned personal adjustment training is a vital ingredient in the deaf client's rehabilitation program.

(3). Independent Living Training (ILT) is a most important part of the MHD client's rehabilitation program.

(a). An ILT Program should place emphasis on classroom instruction in banking, menu planning, grocery shopping, apartment renting, etc.

(b). A supervised "practicum" in the community reduces client dependency and increases his ability to adjust to and maintain independent living status.

(4). Additional comprehensive service facilities for MHD clients are needed as clients from 29 states, the District of Columbia and the Virgin Islands were referred to and served by this Project.

(5). Interpreters for the deaf who can assume roles such as instructor aides, counselor aides, etc., enhance the delivery of services to MHD clients.

(6). Recruitment and training of individuals with potential to be effective rehabilitation workers with deaf clients is a solution to staff shortage.

(7). Staff members who can communicate with and understand the problems of MHD clients increase the chances for clients to successfully complete a program at a comprehensive rehabilitation facility.

(8). The concept of regional rehabilitation centers for low (under) achieving deaf clients is supported by the large number of referrals to the Hot Springs Rehabilitation Center Project from nearby states.

(9). The MHD client's need for supportive and intensive remedial services in conjunction with job-skill training results in long-term and more costly rehabilitation programs.

(10). Successful rehabilitation of multiply handicapped deaf clients requires administrative commitment and support as well as funds to provide the necessary rehabilitation services to MHD clients.

The preceding article was submitted to the Research Review staff by Vernon L. Glenn, Ed.D., Director, Arkansas Rehabilitation Research and Training Center, University of Arkansas, West Avenue Annex, 346 N. West Avenue, Fayetteville, Arkansas, 72701.

Insight into Alcoholic Clients' Behavior Patterns

In my estimation, one of the most prevalent fallacies in the field of alcoholic rehabilitation is the theory that alcoholics go to rehabilitation agencies seeking social, vocational or personal counseling. I strongly believe that these services are farthest from the client's mind when he first visits a rehabilitation facility. Alcoholics may come for many other reasons, usually precipitated by a crisis. Often they come seeking a job after having recently lost one due to inappropriate alcohol usage. They come because of threats made by a probation officer or wife or simply to gain sympathy. They even come on occasion to be chastised for unbearable guilt feelings. Medical problems that have caused fear in the client can also be a motivation. Clients don't see themselves as needing an overhaul, merely a minor tune-up. In fact, they will frequently state, "All I need is a job" or "All I need is for my wife or boss to be more understanding, my mother less domineering or my children more loving."

Strange as it may seem, the alcoholic may be right in not seeking counseling services, since counseling and guidance by themselves, in the initial stages of rehabilitation, are as useful to the alcoholic as psychotherapy is for a year-old child. The alcoholic simply can't use these services and is besides already pretty sick of advice. Advice to him is analogous to a plea for willpower on his part, willpower he does not have.

Since we have established that the alcoholic does not come initially to a rehabilitation office for counseling and that he is under some sort of duress (familial, legal or financial), the chance of success with the client hinges on what we can offer the client that is useful to him. I feel that the needs of the alcoholic are much the same as those of all humans. Primarily, he needs someone to be concerned about him. Simply stated, he needs a "friend", a term which is frequently misunderstood and often used in place of the word "ac-

quaintance". By its most perfect definition, the word "friend" defines every aspect of a truly comprehensive and satisfying human relationship. To be a friend, one must care. When care is felt by the client, then and only then can advice be given, for with friendship comes trust - probably the most necessary yet most often absent quality in the human relationships of the chronic alcoholic. Too often, I have heard that we must be "professional" and not get emotionally involved. I say that professionalism in social work is more than having appropriate information on hand, it includes personal involvement. Professionalism must be synonymous with involvement, since without it we are like cemetery plot salesmen, selling a product which the purchaser is not ready to use. The difference between the cemetery plot salesman and the alcoholic counselor is that the product (sobriety) is much harder to sell. Therefore, it can be stated that a salesman selling sobriety must use techniques directed at building a counselor-client relationship in order to make the product (sobriety) more appealing to the purchaser.

Initially, the counselor must present himself to the client as a non-threatening and non-judgmental figure. He must not patronize the client for his irresponsible behavior. If the initial impression on the client is judgmental or punitive, the counselor will soon find that he has a dwindling caseload. On the other hand, if the counselor allows himself to be manipulated, the client will continue to drink. Alcoholic counselors must convey to the client a sincere desire to help a fellow human being in trouble, nothing more.

The client will usually rebuff early efforts to help him, in fact, in most cases he will totally deny that he has a problem. It is most important for the counselor to understand the alcoholic and that this resistance is normal. He must realize that the alcoholic is very sensitive about being hurt and will fight back at the slightest sign of non-acceptance by the counselor. The client may even attempt to alienate the counselor if he can't find something to dislike about him. Remember that the client will usually withdraw from what he considers to be a hostile environment. Any early effort to push the client toward a commitment will generally heighten his defenses.

Careful listening during the initial contact with a minimum of "advice-giving" is what I have found leads to a second meeting, since the client is less fearful of coming back. The counselor must be unafraid of admitting some of his own weaknesses and share some of himself with the client (a technique utilized by Alcoholics Anonymous members). Professionalism is not in any way threatened by admitting fallibility. When we are afraid to be ourselves, the alcoholic can sense this and will use it to thwart further rehabilitation efforts.

I feel very strongly that alcoholics do not want to be told to have willpower, they want meaningful alternatives to alcohol abuse. Alternatives may be as simple as a good night's sleep, alleviation of painful hangovers or perhaps the ability to walk down the street not fearing that someone they meet might be someone they wronged a day, a week or a year ago. The alternatives may have a more vital character, such as a desire for a happy home, a productive job or a little self-respect. If the counselor feels that these basic needs are not essential to all human beings and if he sees the client as a hopeless drunk, he is defeated before he begins.

Alcoholic counselors must understand the alcoholic's self-hate, low tolerance level for frustration and his dependency traits. One aspect often overlooked is the amazing effect alcohol has on the client. The counselor must realize that for many alcoholics, alcohol may be the only stabilizing factor in otherwise completely disintegrated lives. Although the stability is not stability in the legitimate sense of the word, it is the only thing the al-

coholic has to "hang on to".

Knowing these things, the counselor should not fear hostility directed against him by the client, but should deal with it in a therapeutic way. The hostility may come in the form of a verbal attack or in more subtle ways, such as frustrating the counselor's rehabilitation efforts. The client may even take more overt action such as complaining to supervisors and spreading rumors among various agencies in an attempt to discredit the counselor's abilities. Furthermore, the counselor should not take client failure personally, since what might appear to be failure may simply be a sign that the client is not ready to succeed. We may never see sobriety attained by many clients, but this realization must not defeat the counselor's goals.

We must, if nothing more, present the client with the facts about the social, medical, vocational and psychological implications of his drinking. Then, for the most part, we hope he can achieve sobriety now or perhaps at some future date. What we should recognize is that every alcoholic wants to attain sobriety. If we at least present him with alternative techniques for reaching this goal, we are functioning successfully and may consider failure as perhaps only temporary. The desire to attain sobriety is not always easily recognized, but it can be brought out in a large majority of the alcoholic population through comprehensive counseling.

It should be pointed out that an alcoholic's success greatly depends on other family members. Rehabilitation workers must consider the total family unit as being in need of help. It is imperative to work with the wife or husband and the children of the alcoholic client, even if the client himself is not yet ready to participate in a rehabilitation program. Frequently, counseling with a non-alcoholic member of the family unit may be a prerequisite to working with the alcoholic directly.

Many alcoholics do not respond to one particular treatment technique. For this reason, the alcoholic counselor should be in close communication with all alcohol facilities, such as Alcoholics Anonymous, mental health and mental retardation centers, pastors and family service organizations. The community is also an important aspect to consider in the rehabilitation of alcoholics, since the community's attitude toward alcoholism is unfavorable. Drunks are usually considered funny and alcoholics are thought to be degenerates. This is not only the opinion of the average citizen, it is one frequently held by doctors, pastors and many persons directly related to the social work field. Community enlightenment about alcoholism must be included in the total program. Without community support, the chances for a successful rehabilitation effort are reduced.

Finally, the alcoholic counselor should (in addition to his rehabilitation activities) take part in community prevention programs. He should take an active part in various social and professional organizations, meet with city officials, county judges and school authorities to assist in developing prevention techniques.

It is important to note that this paper was prepared to assist counselors in dealing with unmotivated alcoholics. It is by no means intended to project the idea that one-to-one counseling techniques successfully implemented will lead to sobriety. What I am trying to say is that there are approximately nine million alcoholics in the United States. Relatively few of them are seeking help. If the client is motivated and actively seeks help, Alcoholics Anonymous and other organizations are available to help him deal with his problem. However, the client the alcoholic counselor most often sees is in what we may call the "pre-AA" stage. He has little motivation and almost no insight into

the total implications of alcohol abuse.

The alcoholism counseling report was written for the Research Review by Joseph P. Miscione, Deputy Director, West Texas Regional Adult Probation Department. Mr. Miscione formerly served as a counselor in the Alcoholism Program at the El Paso District Office of the Texas Rehabilitation Commission.

Super Marketing Project for Homebound Enterprises

Presently, many thousands of handicapped individuals sit idle despite the fact that they possess marketable skills. This idleness occurs because of lack of vocational outlet, inability to engage in competitive occupations, lack of available transportation, architectural barriers and many other reasons.

These limitations make small business enterprises or homebound projects potential employment opportunities for the severely disabled.

Experience has shown that small businesses which are service-oriented have a higher success rate than do the product-oriented businesses, yet the product-oriented programs often more readily lend themselves to the capabilities of the severely disabled. The reason for the lack of success of the product-oriented business (when undertaken by the homebound) is the absence of marketing ability and/or a market. If a market is developed for a given product, it often has a greater magnitude than the individual producer can supply. This produces frustration for the consumer which often results in the closing of that marketing outlet.

"Project Supermarket" would involve contracting with private firms having marketing capabilities, so that outlets for products produced by the handicapped might be located. With this marketing capability, vocational rehabilitation personnel could launch a major drive to place more severely disabled persons in this type of employment. Meshed into the marketing firms' contracts would be a feedback system for redirecting product output as demand for a particular item increases or decreases. This feedback information could be passed along to the small entrepreneurs who could utilize it in the development of new products.

In order to meet marketing demands for product volume, additional clients would need to be placed in small independent or collective businesses. As these businesses expanded, their output capabilities would expand the market's coverage.

The Project Supermarket effort would be a natural asset to workshops. The shops could be encouraged to provide more terminal work situations for severely handicapped clients, if the output of these individuals was marketable and to some degree profitable for the workshop. Those facilities which are located in strategic areas could also serve as logical collection points for products of the homebound. Products amassed at the collection point could be subjected to quality control checks and processed for shipping to the retail market.

Project Supermarket could effectively serve three major functions:

(1). Develop an effective marketing system for the homebound and/or workshop client.

(2). Create placement opportunities for the handicapped as market demand increases.

(3). Encourage the development of small businesses which are not dependent upon employment trends.

For the most part, the essential ingredients for a viable program in this area already exist. They exist, however, in fragmented programs. Many workshops have developed sophisticated marketing or contract-procuring procedures. Unfortunately, these capabilities are limited by the production potential of the individual workshop. Many workshops operate complex transportation systems. Most of this transportation activity is utilized to collect salvage materials, but the function of these systems could be easily redirected. The workshops are community-based and operate by means of considerable interagency cooperation. They are capable of rallying the support and assistance of various community agencies in order to fill gaps which might exist in their own limited operations. This ability to marshal widespread support might be the single most important ingredient in a successful Project Supermarket.

Another problem area that the workshops could alleviate is the need to relate to other "people-serving sources". For the homebound project to be successful, it must offer services to individuals who are not clients of a rehabilitation agency as well as to individuals who are. Workshops offer the capacity to extend homebound activities to clients of other agencies.

One critical need which only a rehabilitation agency could fill is the aspect of leadership. Skillful leadership could result in a spirit of mutual cooperation, the development of a statewide network and the creation of a statewide homebound program.

In order to develop a working model of Project Supermarket, a Market Coordinator (a rehabilitation agency central office employee) should be hired to pursue marketing opportunities for clients' products. This position would require:

(1). A basic understanding of workshop capabilities to train, manufacture and deploy into home situations subcontract items

(2). Knowledge of manufactured products that would lend themselves to homebound activities

(3). Close communication with a network of workshops which are capable of bidding on subcontract work or product production

(4). Dissemination of one or more workshop contracts (or portions of contracts) to fulfill commitments

(5). Insistence upon the development of a coordinated team approach in each local sub-unit of Project Supermarket

(6). Communication with workshops to insure program development as needed to support program demands.

A Project Counselor or Counselors should be hired and placed in a pilot project location to serve as the homebound caseload manager(s) of all area homebound cases. The selection of this (these) counselor(s) should be made only after joint agreement with the participating workshop facility.

One Regional Facility Leader should be designated in each pilot project location to serve as a coordinator of multi-facility activities. This officer would be responsible for amassing community agency support to reach the goals of the project. He would also provide for the evaluation, training and establishment of homebound operations and would supply transportation to deliver raw materials and collect finished products from the homebound workers.

John Fenoglio, Director of General Programs, Texas Rehabilitation Commission, prepared the preceding article. Inquiries concerning the ideas he expressed should be addressed to him at the Texas Rehabilitation Commission Central Office, 1600 W. 38th Street, Austin, Texas 78731.

Special Program for the Language-Learning Disabled

The Texas Rehabilitation Commission works with the Texas Education Agency and approximately 600 of the 1,150 Texas school districts in what is called the Cooperative School Program. The major goals of this program are threefold:

(1). To prepare handicapped students for the world of work,

(2). To place these students on jobs in the community when they are ready, and

(3). To help them succeed at their jobs.

In essence, the program helps handicapped students bridge the gap from school to employment by preparing them for "living and earning a living".

In the last three years, a new disability group has been included in the Texas Cooperative School Program. Rehabilitation counselors and Special Education teachers at the secondary school level are working with more students identified as having language/learning disabilities.

Twelve hundred and seventy-two individuals diagnosed as experiencing language and/or learning disabilities were referred to the Texas Rehabilitation Commission by Texas public schools' staffs from July-December of 1973. An additional 595 students with the same disability were referred to the Commission from other sources, such as vocational schools and juvenile probation offices.

Texas Rehabilitation Commission staff devised the following definition to identify a language and/or learning disability:

> Language and/or Learning Disabled students are those who are so deficient in the acquisition of language and/or learning skills including, but not limited to, the ability to reason, think, speak, read, write, spell or to make mathematical calculations, as identified by educational and/or psychological and/or medical diagnosis that they must be provided special services for educational progress. These learning deficits may be associated with below, average and above-average intelligence, emotional disturbance, behavior disorder, environmental disadvantage, per-

ceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia.

In order to justify coding a client as being language and/or learning disabled, specific diagnostic information relating directly to the disability must be identified and documented. Texas Rehabilitation Commission counselors working with the Cooperative School Program request from referring school district personnel the following information on potential language and/or learning disabled clients:

(1). A written assessment revealing evidence of a deficit or deficits in one or more of the basic psychological learning processes (auditory, visual or haptic), intersensory integration and/or concept formation.

(2). A written report of education assessment substantiating a discrepancy between age level expectancy and current educational performance and evidence (academic grade reports and/or achievement test scores) that the discrepancy has existed over a period of time (two - three years minimum).

(3). Documented evidence indicating that the child's learning style deviates so markedly from the norm of his age group that he requires Special Education intervention.

If the counselor is not able to acquire adequate data from the local school district, he should make every effort to purchase necessary diagnostic information.

The counselor must also obtain for the client's records:

(4). A physician's written report indicating general medical findings.

One special program for serving students with this disability is operated by the Corsicana Independent School District. The Language/Learning Disability Project (funded in part by a federal grant and supported by the Texas Education Agency in Austin and the Regional Educational Service Center in Waco) was designed for secondary level students.

In September of 1973, 102 students were identified for the LLD Project (40 16-year olds and 62 15-year olds). Fifty to 75% of these students come from a low socioeconomic background. Many of them are related. The boys in the project outnumber the girls by a ratio of two to one.

The clients in the Language-Learning Disability Project have had access to resource teachers in special classes ("mini-modules") in the areas of science, language arts and math. During the past school year, these students have averaged a one year gain in these subjects as compared with a four month gain for the same time period in the same subjects by an informally selected comparison group. The LLD Project students showed no significant gains in reading.

The rehabilitation counselor assigned to the Corsicana program made home visits with the Project Director to explain the nature of rehabilitation services to a majority of the 40 16-year olds and their families. Many of the students and their parents were very "cautious" about becoming involved in the program. Many of them were difficult to contact to arrange for personal meetings.

Basic services provided to the 16 year-olds by TRC staff have included medical

diagnostics and counseling and guidance. Personal follow-up services are being given to those few students who have already dropped out of school.

It is hoped that many of the student/clients in this LLD Project can remain in "mainstream" education and graduate academically. It is felt, however, that many will not be able to graduate academically and will proceed to a second alternative - that of working at least one semester in full-time employment within the community in order to qualify for their high school diploma. There is a strong possibility that the Texas Rehabilitation Commission can provide vocational-technical training to several of these students prior to or after their graduation.

In conclusion, we anticipate that the number of LLD referrals to the Texas Rehabilitation Commission will continue to increase as school districts gear up their diagnostic tools and identify these students at all levels of the educational spectrum.

Once the impact of Special Education programs which emphasize early identification of educational problems, assessment of the educational needs of each individual pupil, design of an educational plan for each student and periodic pupil reappraisal is felt, we hope that fewer LLD students will be initially discovered at the high school level.

The Texas Rehabilitation Commission has placed renewed emphasis on programs which attempt to work with school-aged handicapped individuals and which provide for "career education" for the handicapped.

The Texas Rehabilitation Commission does not have all the answers to the problems of rehabilitating the language/learning disabled. We do feel that approaching this disability from a vocational angle - emphasizing an individual's strengths rather than his weaknesses - will give the individual, perhaps for the first time, a chance to succeed.

Ron Trull, Program Specialist for the Cooperative School Program, is the author of the language/learning disabilities report. Questions or requests for further details should be sent to him at the Texas Rehabilitation Commission Central Office, 1600 W. 38th Street, Austin, Texas 78731.

Rapid Successes for TRC Correctional Program

The Texas Rehabilitation Commission Adult and Juvenile Correctional Program is relatively new, however, as early as 1966 public offenders were being offered rehabilitation services.

The program was born within the walls of the Texas Department of Corrections when the first rehabilitation counselor was officed there in 1966. This was soon followed by the placement of additional counselors in other correctional institutions housing juvenile as well as adult public offenders. When the Texas Rehabilitation Commission was established as an entity apart from the Texas Education Agency in 1969, the corrections program experienced the beginnings of a rapid period of growth. TRC field offices in major metropolitan areas were staffed with a few correctional counselors to continue the rehabilitation of inmates discharged or paroled from institutions in order to insure a continuity of services upon their reentry into the "freeworld". Both the institutional and field programs flourished, but it soon became apparent that the major impact of correctional rehabilitation would best be realized by redirecting emphasis towards community corrections. In 1970, the Texas Reha-

bilitation Commission applied for and was awarded its first Criminal Justice Council grants. These grants were designed to establish new correctional programs in areas that previously had been dependent upon the Texas Rehabilitation Commission general programs for services. The concept of the specialist counselor in corrections proved to be so successful that in recent years a total of 19 Criminal Justice Council grants have been awarded to the Texas Rehabilitation Commission. These grants have established 40 new staff positions in the correctional program and have been responsible, to a great degree, for the success of the program.

Further development of the community approach to corrections was effected in December of 1972 when the Texas Department of Corrections and the Texas Rehabilitation Commission dissolved their interagency contract. This released a great number of institutional counselors to the field to work in community corrections. These counselors were assigned to key locations throughout the state to develop and implement programs to accept referrals in three primary categories:

(1). Adult and juvenile probation,

(2). Adult and juvenile parole and discharge, and

(3). Federal probation and parole.

Gradually, focus has been shifted from institutional to community corrections. More recently, the Texas Rehabilitation Commission has rechanneled much of its program emphasis to preventive corrections. This effort has been directed toward the pre-delinquent or delinquent youth who has been identified as a child in need of supervision by the juvenile justice system. These young people are referred by family and domestic relations courts, school guidance systems, juvenile courts and probation offices. There are an estimated 58,000 young people in the state of Texas who fall in this category. A great number of them are within a fifteen and one-half to seventeen year old range. Thus they are potential referrals for rehabilitation services.

In the adult program, there are 6,000 dischargees and 3,500 parolees released from the Texas Department of Corrections each year. County adult probation departments have approximately 45,000 people under supervision annually. The four Federal Correctional Institutions in Texas release 1,000 persons a year. Federal Probation and Parole departments list 1,500 individuals per year as being under their supervision. Thus the adult public offender population in Texas totals approximately 57,000 persons.

The combined adult and juvenile correctional rehabilitation programs have access to referral resources which handle over 100,000 persons annually. During the last fiscal year (1972-1973), 16,776 correctional clients were served by TRC personnel. It is readily apparent that there are still "frontiers" to explore in the rehabilitation of this disability group.

Since fiscal year 1971, the correctional program has tripled its production in terms of clients rehabilitated. Last year, correctional clients accounted for 14% of all Texas Rehabilitation Commission successful closures. (This is especially impressive when you consider that corrections is only one of 16 TRC programs for the handicapped).

The "typical" correctional counselor serves 285 clients each year and closes 62 cases annually as "successfully employed". The correctional counselor works very closely with referral sources and is often officed in the same building or facility as the referral source. For this reason, he is often considered as being part of a correctional "team". This rather unique relationship between

the counselor and the correctional referral source is usually formalized in writing by either an interagency contract or an interagency agreement. There are currently 65 such agreements in operation with state parole departments, state institutions, county probation departments, independent school districts, youth service bureaus and guidance centers.

As a result of the accent of contemporary corrections being on the community, a number of pilot programs have emerged that are designed to aid in the public offender's rehabilitation or habilitation. Unfortunately, these programs offer limited services, particularly in the vocational area. Quite often, the staff of such programs seek out and heavily rely upon Texas Rehabilitation Commission programs for supportive services, for they have now recognized the profound effect of employment upon the public offender's total rehabilitation. Such joint efforts have proven to be very effective for clients, as the services of each program complement the other. In the future, it is anticipated that such grant programs and pilot projects will assume even greater roles as referring agencies.

The disability of the correctional client is of major importance in determining the services which will be provided for him. Most clients' primary disabilities are of the mental type, usually in the form of a "behavioral disorder". Physical disabilities are also served. In fact, the entire constellation of disabilities receives attention because a significant number of public offender clients possess multiple mental or physical disabilities. It has been demonstrated that more than 80% of all public offenders are disabled by some form of character or personality disorder. This, in conjunction with past histories of illegal behavior, job failure, social maladjustment, poor educational achievement, etc., frequently constitutes a serious vocational handicap. The correctional counselor must be innovative enough to devise a plan which will alleviate the disability and the handicap to an extent that the client can function vocationally or he must formulate a plan that will permit the client to function vocationally in spite of his handicap. Often, experiencing job success in itself does much to correct the client's disability, as it provides a basis for identity, security, and the development of a positive self-image, something with which the public offender is unfamiliar. In such an event, the end is often indistinguishable from the means.

It has been clients' successes which have built the Texas Rehabilitation Commission Correctional Program into what it is today, a dynamic and vital component of the Texas Criminal Justice System.

The previous summary of the TRC Correctional Program was prepared by Steve Bonnell, Program Specialist. Requests for additional data should be addressed to him at the Texas Rehabilitation Commission Central Office, 1600 W. 38th St, Austin, Texas 78731.

HOPE for Handicapped Aggie Student-Clients

TRC Counselor Don Gardner has been working with Texas A&M University officials and handicapped "Aggies" to try to solve some of the problems faced by students in wheelchairs on the A&M campus.

These efforts have resulted in HOPE (Help Our People Excel), an organization of handicapped students.

On November 16, 1973, a meeting was held to discuss the feasibility of begin-

ning such a student-led group for the handicapped at Texas A&M. As a result of this session of idea-sharing by University officials, handicapped students, TRC student-clients and Counselor Gardner, it was determined that there was indeed a need for such an organization and that it should have TAMU administrative support.

After the initial meeting, progress came quickly. A questionnaire was sent by Counselor Gardner to all Texas Rehabilitation Commission clients attending Texas A&M University. Responses indicated that the majority of the clients were interested in joining and supporting the new group.

At a student meeting on February 21, 1974, an acting president was elected, and committees were selected to work on special projects, develop a constitution, present a slate of officers and propose names for the organization. In order to be officially recognized by the University administration, the club had to accomplish these activities and obtain faculty sponsors.

One week later, HOPE (Help Our People Excel) was chosen as the group's name and a constitution was adopted. The organization's objectives are to provide an awareness of the problems of disabled students and to promote the removal of architectural barriers to ensure access for all students to all campus facilities.

On March 7, Dr. Paul H. Newell, Jr., Professor and Head of the Rehabilitation Engineering Center, and Mr. George J. Mann, Associate Professor of Environmental Design (Architecture), agreed to be faculty advisors for HOPE. Both of these men have a great interest in the handicapped and should be assets to the organization.

The basic purposes of the group are to help the University's administration understand the needs of handicapped students and for the students to help one another with special problems that may arise.

One of the first efforts that HOPE undertook was the preparation of a handbook to assist new students in finding ramps, elevators, restrooms and water fountains. A new project was begun during the spring semester - Project Awareness Day. On this day, non-handicapped members of the administration, faculty and student body of Texas A&M were to be confined to wheelchairs to help them understand the hardships faced by wheelchair students. In conjunction with this activity, a wheelchair basketball game was scheduled in DeWare field house.

The organization has now grown to over 40 active members. This talented and enthusiastic group should certainly win benefits for the handicapped at Texas A&M University and in the Bryan-College Station area.

Readers interested in more information about HOPE should write to Counselor Don Gardner, YMCA Building, Room 309, College Station, Texas 77843.

Job-Keeping Skills from Job Readiness Program

What do you do with a client who's ready to go to work but not prepared to go and interview for a job? What can you do with a client who wants to enroll in a particular training school, but you don't know how he'd do? What can you do with a client who has been in status "02" for a long time and, for many reasons, looks like he'll be there even longer?

The Fort Worth Southwest District Office has a program which is trying to find solutions for you and for your clients. Job Readiness is the name of the project and its problem-solving efforts are now fully operational.

Pre-Vocational Counselor Sharon Carpenter is responsible for implementing the unique TRC effort. While developing Job Readiness plans, Sharon asked counselors

representing all TRC programs what they thought should take place in a Job Readiness project. She took note of their problems, requests and advice and designed a program which can be tailored to fit many individual client needs.

Some counselors asked for a short session to help clients ready to go to work but who would be unable to keep jobs for lack of social skills. Such clients have completed vocational training programs and have job skills. These individuals have reached the point where they must sell themselves. They must fill out job applications, must understand what is expected of them and must learn what they can get away with and what they can't. Ideally, Job Readiness should be this type of client's "last step" before looking for a job.

Counselor Carpenter often gets referrals of clients in "02" status, as some Ft. Worth area counselors have 150-200 people on their caseloads in this status. For these clients, Sharon combines the roles of pre-vocational counselor, job placement specialist, general counselor and program developer in order to provide services to alleviate their rehabilitation problems.

Clients in any status may be referred to the Job Readiness program, where they are accepted on a temporary basis as courtesy cases.

The first Job Readiness session began on April 29 and ended on May 24. Eleven clients were served during the month-long program which was directed toward helping the clients get the jobs they wanted and teaching them how to keep the jobs once they had been hired. To accomplish these major goals, the following areas were stressed:

(1). Increasing self-awareness

(2). Learning how to fill out a job application correctly and effectively

(3). Increasing self-confidence when being interviewed

(4). Understanding difficult questions that might be asked on a job interview

(5). Learning how to sell one's self to an employer

(6). Learning how to manage money by developing a personal budget

(7). Discovering how to use public transportation

(8). Discussing ways to keep a job

(9). Discussing why people lose jobs

(10). Learning how to have a happy productive life

The first group of Job Readiness participants represented many disability groups:

Floyd - 45-year old hemiplegic

Ed - 17-year old high school dropout - cerebral palsied

Edward - 72-year old civil engineer - alcoholic

Dory - 17-year old school dropout - obese

Lisa - 16-year old high school dropout - behavioral disorder - was on drugs

Barbara - 53-year old mentally restored (severe depression)

Virgil - 16-year old school dropout - juvenile offender

Mark - 22-year old ex-addict (heroin)

Cookie - 16-year old school dropout - juvenile offender - was on drugs

Patty - 17-year old mentally retarded - obese

Lupe - 16-year old school dropout - juvenile offender

One of the project's first successes came early during the second week of the program. Lisa (the 16-year old dropout with a behavioral disorder - formerly on drugs) was chosen for a job over seven other applicants by the manager of a new Dairy Queen. The employer selected Lisa because she filled out the application forms in one-third the time as did the other applicants and because she looked him in the eye during the interview - something Lisa never did before attending JR classes.

The Job Readiness program may fill educational gaps in reading and math skills by presenting materials in "work form" - sales slips, sales taxes, warehouse receipts, etc., but it is not intended to be a substitute for Adult Basic Education. Currently, an instructor for project clients is provided through an agreement with Tarrant County Junior College. One novel teaching aspect has been to involve community businessmen in the program. For example, a banker was asked to speak to the group about checking and savings accounts. An employer was recruited to explain to the group why persons are hired and why certain individuals are fired.

Job Readiness serves different functions than does the New Careers Program. New Careers clients already have jobs and therefore do not endure the pressures of trying to find employment. The JR project emphasizes job readiness, job (career) exploration and selling one's self to an employer.

Job Readiness is not a duplication of halfway house services which stress work-related skills. The Ft. Worth program encourages the development of social skills and personal talents.

Job Readiness is not a double for vocational evaluation. A client in vocational evaluation is interested in learning what he can do vocationally. He is not primarily interested in whether he gets there on time, etc. These clients often accomplish very little in the area of personal/social adjustment, because they did not go to vocational evaluation for that purpose.

PA/VR Project efforts cannot be substituted for Job Readiness. The JR clients are not receiving welfare monies and are thus ineligible for the PA/VR programs. Frequently, the Job Readiness clients are not in need of the academic training offered by the PA/VR Projects.

Counselor Carpenter plans to keep the JR program flexible in order to be able to adapt to best serve client needs. Perhaps the course may be shortened or expanded. At the present time, she feels that a small group (a minimum of eight and a maximum of thirteen) is best served by the Job Readiness project. Hopefully, all of the group members would be admitted to the course at the same time.

At some time in the future, Job Readiness may be expanded to two additional Ft. Worth TRC offices - the Ft. Worth Northwest District Office and the Ft. Worth Southeast District Office.

TRC Counselor Sharon Carpenter, Ft. Worth Southwest District Office, contributed the information for the report on the Job Readiness Program. Requests for additional details may be addressed to her or will be forwarded through the Research Utilization Office.

Library Materials

The following books, Research and Demonstration Grant Final Reports and films are available for your use on a loan basis from the Texas Rehabilitation Commission Library. Materials may be requested from the Research Utilization Office, Texas Rehabilitation Commission, 1600 W. 38th Street, Austin, Texas 78731. Please include the number which appears prior to the description of the publication/film and the phrase "1974 Spring Edition of the *Research Review*".

As the Research Utilization Grant for HEW Region VI expired on May 31, 1974, this is the last issue of the *Research Review* which will be widely distributed throughout the region. The publication will continue, but it will be mailed primarily to rehabilitation practitioners in Texas. Questions about the *Research Review's* circulation should be addressed to Randall Scott, editor.

Books

1. *Weighted Case Closure for More Appropriate Evaluation of Vocational Rehabilitation Counselors.* Silver, Diana Lee.

2. *Mental Health and the Deaf: Approaches and Prospects.* Altshuler, Kenneth.

3. *Orientation Training for Vocational Rehabilitation Counselors: A Syllabus on Special Problems of the Deaf and the Hard of Hearing.* American Hearing Society.

4. *Education of the Deaf: The Challenge and The Charge.* Babbidge, Homer D.

5. *Effective Vocational Guidance of the Deaf.* Berger, David G.

6. *Factors Contributing to Successful Rehabilitation of Deaf Clients.* Bolton, Brian.

7. *Family Stress Associated with Early Childhood Deafness: Consequences and Aspects of Prevention.* Bolton, Brian.

8. *Introduction to Rehabilitation of Deaf Clients.* Bolton, Brian.

9. *New Vistas for Competitive Employment of Deaf Persons.* Craig, William N., editor.

10. *Multiply Disabled Deaf Persons: A Manual for Rehabilitation Counselors.* Crammatte, Alan B., editor.

11. *I'll Quit Tomorrow.* Johnson, Vernon.

12. *Defensive Thinking in Alcohol Addicts.* Bell, R. G.

13. *Social Workers Can Help Alcoholics.* Cork, Margaret.

14. *Potential for Rehabilitation of Skid Row Alcoholic Men.* Hart, Walter C.

15. *The Adjustment of the Family to the Crisis of Alcoholism.* Jackson, Joan K.

16. *The Alcoholic Personality: Research in Differential Personality Patterns.* Lawlis, G. Frank and Rubin, S.

17. *Alcoholism in Industry: Modern Procedures.* Trice, Harrison M.

18. *The Alcoholic Offender.* Wippel, Robert R.

19. *Identifying the Problem Drinker on the Job.* Trice, Harrison M.

20. *Development of Modern Vocational Objectives for Severely Disabled Homebound Persons.* Shworles, Thomas R.

21. *Programmatic Research on the Rehabilitation of the Homebound.* Federation of the Handicapped.

22. *A Development Project in Self and Home Employment for the Homebound.* Gentile, Frank D.

23. *Making Money at Home: 63 Fascinating Projects.* Shields, Earl B.

24. *Technological Change and New Vocational Opportunities for the Homebound Severely Disabled.* Shworles, Thomas R.

25. *Recreation for the Homebound Person with Cerebral Palsy.* Thompson, Morton.

26. *New Productive Capability and Earnings of Physically Disabled Homebound Persons.* Shworles, Thomas and Mallik, Kalisankar.

27. *A Guide to Comprehensive Services to the Homebound Disabled.* Tickton, Reva S., editor.

28. *Learning Disabilities.* McCarthy, James L.

29. *Leadership Training Institute in Learning Disabilities.* Bryant N. Dale. (University of Arizona). Two volumes.

30. *Methods for Learning Disorders. (sic)* Myers, Patricia and Hammill, Donald.

31. *Guidelines for Teaching Children with Learning Difficulties.* Northeast Independent School District (San Antonio).

32. *Characteristics of the Child with Learning Disabilities.* Beckman, Kenneth.

33. *Emotional Disturbance and School Learning: A Book of Readings.* Clark, Donald and Lesser, Gerald S.

34. *The Education of Handicapped Children.* The Education Commission of the States. Hensley, Gene, editor.

35. *How Children Fail.* Holt, John.

36. *Developing Attitude Toward Learning.* Mager, Robert F.

37. *Differential Academic, Behavioral and Psychological Test Profiles of Four Types of Learning Handicapped Children.* Hartlage, Lawrence, C.

38. *Psychological Assessment of Patients with Brain Injury.* Levinshon, Peter.

39. *The Mentally Retarded and the Juvenile Court.* Haskins, Jimmy R.

40. *Social and Vocational Rehabilitation of Juvenile Delinquents.* Goldberg, Richard T.

41. *Manual of Correctional Standards.* American Correctional Association.

42. *Closing Correctional Institutions.* Bakal, Yitzhak, editor.

43. *Modeling and Group Discussion in the Rehabilitation of Juvenile Delinquents.* Sarason, Irvin G.

44. *The Integration of Services for the Prevention of Delinquency.* Ageton, Rex.

45. *The Mentally Retarded Offender.* Brown, Bertram S. and Courtless, Thomas F.

46. *Juvenile Delinquency, the Family and the Social Group.* Mays, John B., editor.

47. *Community Based Rehabilitation Services for Youthful Offenders in a Rural Area.* Dunn, Dennis J.

48. *Behavior Modification: Issues and Extensions.* Bijou, Sidney W., editor.

49. *Architectural Planning for the Physically Limited Student.* Kennedy, W. T.

50. *The Psychology of College Success: A Dynamic Approach.* Lindgren, Henry A.

51. *Wheelchair to Independence.* Gutman, Ernest M.

52. *How to Visit Colleges.* National Vocational Guidance Association. (A pre-college manual for students).

53. *Educational and School Equipment for Physically Disabled Students.* Yuker, Harold E.

54. *Schools Without Failure.* Glasser, William.

55. *Selected Career Education Programs for the Handicapped.* Marland, S. P.

56. *Intensive Services for the Socially Disabled.* Illinois Division of Vocational Rehabilitation.

57. *What Do You Say After You Say Hello?* Berne, Eric.

58. *Materials for Occupational Education: An Annotated Source Guide.* Schuman, Patricia.

59. *Employers' Attitudes Toward Hiring Deaf Clients.* Cihlar, Carl Lee.

60. *Combating Stigma Towards Physically Disabled Persons.* English, R. William.

61. *Changing Employment Policies and Attitudes Towards Persons with Epilepsy.* Sands, Harry.

62. *The Untapped Human Resource: The Urban Negro and Employment Equality.* Levine, Marvin J.

New Books

63. *Mexican Americans.* Moore, Joan W.

64. *Standards for Private Supervised Living Facilities.* Arkansas Department of Social and Rehabilitative Services.

65. *Competency to Stand Trial and Mental Illness.* Harvard Medical School.

66. *Telephone Services for the Handicapped.* Sullivan, Richard A.

67. *Films on Mental Retardation: A Select Annotated Bibliography.* McGovern, Kevin B.

68. *So You Want to be a Supervisor!* Reeves, Elton T.

69. *Development of Orthotic Systems for the Quadriplegic Patient.* Mortimer, J. Thomas.

70. *Clinical Interpretation of the Wechsler Adult Intelligence Scale.* Zimmerman, Irla Lee.

71. *The Rational Manager: A Systematic Approach to Problem Solving and Decision Making.* Kepner, Charles H.

72. *Behavioral Management of Stuttering.* Perkins, William H.

73. *Blind and Deaf Study.* Mallas, Aris A. (Three volumes).

    A. *Blind and Deaf Study*

    B. *Blind Study*

    C. *Deaf Study*

74. *Signing Exact English.* Gustason, Gerilee.

75. *Rehabilitation for the Unwanted.* Roth, Julius A.

76. *Readings in Welfare Economics.* Arrow, Kenneth J., editor.

77. *A Manual for Agency Personnel on Effective Working Procedures with the Deaf Retarded.* Texas Tech University - R&T Center.

78. *Management Practices in Vocational Rehabilitation District Offices.* Viaille, Harold G.

79. *Measurement of Social Incompetency in Adolescents.* de Jung, John E.

80. *A Home-Based Tape Recorder Approach to Rehabilitating the Stutterer.* McGough, W. Edward.

81. *The Employment of AFDC Recipients in Michigan.* Smith, Vernon K.

82. *Behavior Identification Format.* Materials Development Center - University of Wisconsin.

83. *Child Development Policy for Texas.* University of Texas - LBJ School of Public Affairs.

84. *Drug Dependence and Rehabilitation Approaches.* Hardy, Richard E.

85. *How to Use Adding and Calculating Machines.* Walker, Arthur L.

86. *Schizophrenics in the Community.* Pasamanick, Benjamin et al.

87. *Personal Relationships, The Handicapped and the Community.* Lancaster-Gaye, Derek, editor.

88. *Neuromuscular Function Measures in Hemiplegia.* Simons, David G.

89. *Schools Certified Under the Texas Proprietary School Act and Schools Offering Courses Approved for Veterans.* Texas Education Agency.

90. *A Visual Motor Gestalt Test and Its Clinical Use.* Bender, Lauretta.

91. *Disabled Families: A Study of a Link Between the Social Contribution of the Disabled and the Retardation of their Rehabilitation in the Family Context.* Klausner, Samuel Z.

92. *Clothes to Fit Your Needs.* Yep, Jacqueline.

93. *A Bibliography on Drugs by Subject and Title.* Richardson, Winifred.

94. *Strategies for Working with the Inner-City Poor.* Trela, James E.

95. *Human Sexuality of the Mentally Retarded.* de la Cruz, Felix F., editor.

96. *Objective Indices of Severity of Chronic Aphasia in Stroke Patients.* Smith, Aaron.

97. *The Adolescent Gap - Research on Drug-Using and Non Drug-Using Teens.* Scott, Edward M.

98. *Peoplemaking.* Satir, Virginia.

99. *Services to the Blind: A Community Concern.* Vail, Morgan. (Eleventh Institute on Rehabilitation Services).

100. *Curso Basico en Communicacion Manual.* O'Rourke, Terrence J. (Translated by Frances M. Parsons).

101. *Rehabilitation of the Drug Abuser.* Kolber, Phillip. (Ninth Institute on Rehabilitation Services).

Final Reports

102. *A Study of Lymphedema in the Cancer Patient.*

103. *The Neuropsychology of Spatially-Oriented Behavior.*

104. *Community Programs to Facilitate the Rehabilitation of Persons with Epilepsy.*

105. *Suggested Publications for Developing an Agency Library.*

106. *Rehabilitation of Federal Target Groups.*

107. *Symbolic and Linguistic Processes in the Deaf.*

108. *UC-BL Dual Axis Ankle Control System: New Applications and Basic Studies.*

109. *Local Problem-Solving and Human Services.*

110. *Sensory Denervation: A Study of Its Cause and Prevention in Leprosy and the Management of Insensitive Limbs.*

111. *Self-Study and Evaluation Guide for Sheltered Workshops.*

112. *Study in Workmen's Compensation in Relation to Sheltered Workshops.*

113. *Testing the Applicability of Existing Telecommunications Technology in the Administration and Delivery of Social Services.*

114. *Postural Determinants in the Blind.*

115. *Legislative Information Needs.*

116. *Project Star (Serving to Advance Rehabilitation).*

117. *A Study of Spinal Orthotics in Idiopathic Scoliosis.*

118. *Vocational Rehabilitation in a Suburban Community Hospital.*

119. *Psychiatric Disability, Work Adjustment and Rehabilitation.*

120. *Work Adjustment: A Dynamic Rehabilitation Process.*

121. *Tests and Measurements for Vocational Evaluators.*

122. *Professional and Client Viewpoints on Rehabilitation Issues.*

123. *Vocational Rehabilitation of Disabled Public Assistance Clients.*

124. *Community Role in the Rehabilitation of Persons with Epilepsy.*

125. *Work Values of the Handicapped.*

126. *Out Plant Supervised Janitorial Service Employing the Mentally Retarded.*

127. *Body Training Toward Self-Esteem and Employability of Adolescents.*

128. *Biomedical Research Program on Cybernetic Systems for the Disabled.*

129. *The Rehabilitation of the Cardiac Patient.*

130. *Vocational Rehabilitation and Cardiac Surgery.*

131. *Socioeconomic and Other Variations Related to the Rehabilitation of Mexican-Americans in Arizona.*

132. *The Offender Looks at His Own Needs.*

133. *Psychiatric Diagnosis, Therapy and Research on the Psychotic Deaf.*

134. *The Assessment of College Experience of Severely Handicapped Individuals.*

135. *A Psychological Test Battery for Predicting Success in Prosthetic Rehabilitation.*

136. *The Rehabilitation of the Young Epileptic: Dimensions and Dynamics.*

137. *A Comparative Study of Total Hip Replacement Prostheses.*

138. *Arthritis Manual for Allied Health Professionals.*

139. *Diversifying Job Opportunities for the Adult Deaf.*

140. *The Self-Concept and Psychopathology.*

141. *Florida Project on Follow-Up Adjustment of Alcoholic Referrals for Vocational Rehabilitation.*

142. *An Assessment of Vocational Realism of High School Mentally Retarded Adolescents.*

143. *To Develop Work Evaluation and Work Training Techniques Designed to Facilitate the Entry of Mildly Mentally Retarded into Service Occupations.*

144. *Objective: Vocational Rehabilitation Within Public Education.*

145. *The Severely Disabled Person is Rehabilitated.*

146. *The Post-Hospital Schizophrenic Patient.*

147. *Rehabilitation Counselor Functions: Annotated References.*

Cassette Tapes

148. *Dr. Ralph Blair discusses counseling with homosexual clients.* (no title).

149. *Dr. Franklin Westbrook chairs a panel discussion on the counseling of minority clients by Anglo counselors.* (no title).

150. *Sex Problems in Paraplegia.*

151. *Psycho-Social Vocational Factors in Hemiplegia.*

152. *Rehabilitation of the Cardiac Patient.*

153. *Psychological and Psychiatric Factors in Rehabilitation.*

154. *The Handicapped in Industry.*

155. *The Mentally Retarded in Industry.*

156. *Rehabilitation and the Family.*

157. *Occupational Therapy in Physical Disabilities.*

158. *Epilepsy.*

159. *Rehabilitation of the Patient with Rheumatoid Arthritis.*

160. *Selective Placement of the Handicapped in Industry.*

161. *"A Safe Passage" - Barrier Free Architecture.*

162. *"How Do You Feel?"*

163. *Work Adjustment Training: Its Dynamics and Methodology.*

164. *The Growing Edge of Vocational Rehabilitation.*

165. *Reality Therapy.*

166. *Talk at Day of Reporting.*

167. *Toward a Systems Approach to Evaluation and Adjustment Services.*

168. *How to Select, Administer and Interpret Psychological Tests.* (Cassette tapes accompanying a book of the same title by Moriarty, Joseph A.).

Complete List of Films

169. *Distant Drummer Series* - Three films concerned with drug abuse and its treatment.

A. *Moveable Scene* - hallucinogenic drugs.

B. *Flowers of Darkness* - opium and heroin.

C. *Bridge From No Place* - treatment and rehabilitation of addicts.

170. *Say It With Hands* - A series of twenty-six films designed to teach the signed language.

171. *The Glass Wall* - An exploration of the problems accompanying hearing loss.

172. *Comeback* - A demonstration that properly prepared handicapped workers make good employees.

173. *Fragile Egos* - A film depicting the psychiatric rehabilitation of a former mental hospital patient.

174. *Jobs Well Done* - An account of the successes of mentally retarded workers in governmental agencies.

175. *Help on Wheels* - A film which illuminates the problems of handicapped individuals and the problems faced by families having one or more disabled members.

176. *New Day for Epileptics* - Presentations of actual case histories of epileptics.

177. *Selling One Guy Named Larry* - An illustration of many jobs in private industry which mentally retarded persons are capable of filling.

178. *Opportunities Unlimited* - An explanation of vocational rehabilitation services from physical therapy through job placement.

179. *Sound the Trumpets* - An illustration that architectural barriers in many public buildings severely limit the normal daily activities of many handicapped people.

180. *Only Human* - A series of brief real-life situations to encourage persons who may be in need of vocational rehabilitation services to overcome their reluctance to seek aid.

181. *Black and White: Uptight* - "The myths that perpetuate prejudice against black people in our society and the subtle ways that hate is learned are explained in this film."

182. *Voice of La Raza* - This film centers around "the problems in job discrimination faced by Spanish-surnamed Americans; it also embraces social and cultural issues."

183. *Changes* - This media presentation deals with the problems faced by persons experiencing the trauma of para or quadriplegia after leading normal lives. It covers in an inspiring manner many difficulties encountered

by the "newly disabled" including emotional reactions, architectural barriers, etc.

184. *Like Other People* - The focus of this English film centers on the social and emotional needs of mentally and physically handicapped persons - specifically the cerebral palsied.

185. *212912* - This film depicts the daily life of an inmate at a Texas correctional institution.

186. *Justice, Liberty and the Law* - This educational presentation stresses appreciation of the origins of values underlying the Bill of Rights and consideration of personal attitudes toward justice and liberty.

The titles of the following four films are self-explanatory. They would be useful in preparing clients for selecting and obtaining a job.

187. *Applying for a Job.*

188. *Communicating with the Public.*

189. *Getting a Promotion.*

190. *Working Together.*

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RESEARCH REVIEW

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