RESEARCH REVIEW

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TEXAS REHABILITATION COMMISSION

RESEARCH REVIEW

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Dallas Post Office Hires Deaf LSM/ZMT Operators

With ever greater frequency, vocational rehabilitation counselors are being asked to aid in the job placement of handicapped workers. It sounds like a simple procedure, but far more is involved in this placement process than meets the eye. The counselor must provide a series of initial and follow-up services to insure the success of the newly-hired handicapped workers.

In September of 1972, the Dallas Post Office decided to employ a tour of handicapped workers. (A tour is a Post Office term for a unit of twenty employees.) A meeting was held to inform the Dallas Postmaster about Texas Rehabilitation Commission services and about the abilities of TRC work-ready clients. As a result, Post Office officials requested that Texas Rehabilitation Commission personnel assume the responsibility for the medical and psychological screening of all applicants for those twenty positions.

Employees in the tour would use LSM/ZMT equipment (zip code machinery). When in operation, this equipment has a noise level of 86 decibels. Constant exposure to such a noise level can be damaging to hearing. To prevent hearing loss, Dallas Post Office officials had installed noise protection devices, including earphones and insulation.

It was determined that the positions available in the tour could best be filled by TRC clients who were deaf. It was stressed that the Texas Rehabilitation Commission could provide a full-time interpreter for these clients during their training period. Care was taken to explain to the Post Office training officer the problems which might occur during the training process.

Experience has indicated that it is important to involve management personnel in the early stages of the hiring process. For example, if a line supervisor is not pleased with an employee or is not involved in the selection of an employee, difficulties could result which might jeopardize the success of an entire project. For this reason, the TRC provided in-house training for Dallas Post Office supervisors to acquaint them with the abilities and limitations of the handicapped workers to be hired for the tour. The Texas Rehabilitation Commission also supplied an interpreter who taught sign language classes three times a day. Over a period of three years, approximately 120 Post Office employees have participated in the manual communication classes.

During the psychological testing part of the employee screening process, the Performance Scales of the WAIS were administered. Results indicated that persons functioning in the average range of intelligence had the greatest potential for success. Through testing, it was discovered that individuals with IQs in the subnormal range had significant difficulty in performing the tasks which are required in this job. It was discovered through experience that persons with above-average IQ scores were not inclined to remain employed in this position because operation of the LSM/ZMT soon becomes boring for them.

The Revised Beta Examination was also administered as a test of memory skills and clerical perception. (Most Post Office job routines are learned by rote.) The Minnesota Paper Form Board for clerical ability was found to be a reliable instrument for identifying individuals with good prospects for success in the Post Office jobs.

The Bender Gestalt Visual Motor Test was given to measure perceptual abilities. Experience showed that potential employees needed to be able to draw figures with little difficulty in order to function adequately on the job.

Medical standards for the LSM/ZMT operator's job are that an applicant be in good health, be able to lift 50 pounds and meet certain vision requirements. Epileptics and diabetics who use more than 25 units of insulin a day are not considered for the operators' positions.

During an orientation session, prospective employees were advised that they would work from 3:30 p.m. until midnight and on weekends. It was explained that these working hours might cause hardships to family and social relationships. The orientation session stressed both positive and negative aspects of employment to insure that each client understood the responsibilities of the job.

Although many applicants felt that the benefits of good wages would outweigh the curtailment of social activities, it became apparent that clients could not evaluate the disadvantages of working the evening shift until they had actually done so. Often clients needed money management counseling in order to wisely budget their salaries. Continued personal and social counseling was needed by the tour of deaf employees.

One problem was encountered after training had begun. Deaf people count by using their little finger to indicate "6", ring finger for "7", middle finger for "8", pointer finger for "9" and thumb for "10". On the LSM/ZMT machine, the numbers 7 and 8 appear in a sequence which is opposite to the order used by the deaf to count.

LSM/ZMT MACHINE

By drawing this number sequence on paper and memorizing it, deaf clients were able to reduce this difficulty.

Although all screening procedures were performed by TRC personnel, Post Office officials made the final decisions concerning which applicants were hired. Post Office regulations were strictly followed. Because the initial tour of deaf employees proved to be so successful, the Dallas Post Office has now hired seventy deaf workers.

This summary of the Dallas Post Office experiment in the hiring of the handicapped workers was contributed to the Research Review by Counselor Joyce Stricklen, Dallas North District Office, 5510 Abrams Center, Suite 115, Dallas, Texas 75214.

'Personal Achievement Skills' Data Are Collected

Developed by the Arkansas Rehabilitation Research and Training Center, Personal Achievement Skills training focuses basically on teaching participants the skills of self-modification in a group context. Program skills (helping, value clarification and problem solving) are integrated in an exercise or skill-based approach to counseling.

Early efforts to develop Personal Achievement Skills included a study with college students at the University of Arkansas. The purpose of the initial study was to develop materials and train leaders for Personal Achievement Skills groups. Outcomes of this session indicated that the program was rated very positively by participants and individual leaders. Although no experimental changes in such variables as self-concept or internal-external control were noted, most participants reported goal attainment.

The initial study led to the development of a teacher's manual, participant's workbook and supplementary papers on the philosophy of Personal Achievement Skills, the development of behavioral programs and the evaluation of program outcomes.

Another developmental study involving a college population was conducted at the University of Arkansas. These participants also enjoyed the program and, for the most part, achieved their goals. No change in self-report measures such as self-concept or internal-external control was noted.

While the pilot programs at the University of Arkansas were being completed, several PAS sessions involving rehabilitation clients were conducted at the Hot Springs Rehabilitation Center. Results of these programs indicated that the clients enjoyed participating in Personal Achievement Skills groups. Leaders noted that clients were also profiting from their involvement in Personal Achievement Skills. Evidence of desired outcomes was seen in terms of goal attainment.

A Personal Achievement Skills training session for rehabilitation personnel involved in personal adjustment training was held in February 1974. As a result, the Personal Achievement Skills program was implemented at the Criss Cole Rehabilitation Center for the Blind in Austin, Texas. Although no research data are available regarding program impact, Criss Cole personnel state that PAS training has become a significant part of their program.

Rehabilitation professionals were also exposed to PAS training at the Arkansas Chapter meeting of the National Rehabilitation Counselors Association in June 1974 at Arkansas State University in Jonesboro. The research study "An Evaluation of Personal Achievement Skills by Rehabilitation Personnel" indicated that rehabilitation counselors felt the program was most appropriate for rehabilitation clients. In essence, participating counselors observed that the training program had helped them both personally and in their roles as counselors. They felt that rehabilitation clients would profit from involvement in Personal Achievement Skills.

Two endeavors to collect PAS data are currently underway. One project at a local high school has almost been completed. The other program, a study of Personal Achievement Skills in a work adjustment center, is just beginning.

Findings from the high school project indicated that the students enjoyed the project and achieved their goals. For the first time, a statistical trend toward a gain in self-concept as a function of Personal Achievement Skills appeared. On an informal basis, there was some mention of the fact that guidance services were used with greater frequency by students in the PAS group.

The most significant research study currently underway regarding Personal Achievement Skills' impact is being conducted in the work adjustment center at the Hot Springs Rehabilitation Center. PAS training, led by a work adjustment staff member, is a regular part of the Center's curriculum.

The research design for this project involves both experimental and control groups. Clients are randomly selected either for a Personal Achievement Skills group or for instruction in personal hygiene. Variables for estimating project effectiveness include: goal attainment, changes in time perspective,

self-rating on work adjustment behaviors, self-rating on a vocational orientation questionnaire, Center outcome and long-term employment data.

Experiences with PAS training in the work adjustment center indicate that it is a very popular program among participants. The Personal Achievement Skills session has not only introduced students to communication skills and goal setting, but has provided a context for meaningful interaction among students in interpersonal relationships and personal problem situations. It is hoped that the experimental study in the work adjustment center will serve as a foundation for additional studies in Region VI facilities and field offices to determine the effectiveness of Personal Achievement Skills training.

Dr. Roessler prepared this summary of Personal Achievement Skills training for the Research Review. Additional information about PAS training can be obtained from Richard T. Roessler, Ph.D., University of Arkansas, Arkansas Rehabilitation Research and Training Center, 346 North West Avenue, Fayetteville, Arkansas 72701.

Contractual Counseling Sets Goals and Duties

Contractual counseling is a technique that has often been overlooked by rehabilitation counselors in state agencies. In reviewing the literature, it was difficult to find any references to contractual counseling. No references were found concerning the application of the technique in state Vocational Rehabilitation District Offices.

Contractual counseling is an example of behavioral counseling and behavioral self-control techniques. This approach helps the counselor and client set specific goals and a logical sequence of behaviors to achieve these goals. The "contract" is a plan of action developed in counseling which is accepted by both the counselor and the client as a good way to proceed. The client assumes responsibility for his own behavior under this technique and he clearly understands the role of the counselor in assisting him.

The "contract" can be used in the early stages of the rehabilitation process when the client and the counselor agree that it is a useful technique. If the client does not appear to be highly motivated, the counselor may consider the use of a "contract" during the diagnostic phase. This "contract" would probably state the reasons the diagnostic information is needed by the counselor and the client. An emphasis might be placed on how the client will benefit from this information. The client would agree to keep all appointments with physicians and others so he can benefit from VR services.

When the diagnostic process is completed, the counselor and the client can plan the rehabilitation services that are indicated and discuss how these services will assist the client in reaching his goals. Counseling could be directed toward helping the client examine as many alternative goals and ways of reaching these goals as possible.

In counseling with the client, goals should be established in terms of clear observable behaviors so progress can be measured by the counselor and the client. The plan of action to achieve the contracted goals should be broken

down into small steps to assist in monitoring progress toward achieving the goals. These steps should also be stated in terms of observable behaviors so progress can be easily measured.

If the goals include personal/social or work adjustment behaviors to be modified, the behavior in question should be stated in terms of observable characteristics. The conditions in which this behavior occurs should also be stated. This should be done so the client is aware of these conditions which may reinforce or encourage the undesired behavior. A plan of action should be developed which could easily be carried out by the client himself. The client might be encouraged to keep records of the problem behavior to assist himself in changing his behavior. This can be done only if the client is aware of the behavior when it occurs.

A goal should be stated in clear terms so that the counselor and the client can agree when the goal has been reached. The goal should also be defined on several levels, such as:

a.) best expected outcome
b.) acceptable outcome
c.) unacceptable outcome

This will allow the client to partially meet the goal without feeling that he has completely failed.

The counselor can provide feedback to the client on the client's progress in meeting established goals. The counselor can also report on the counselor's progress in providing services outlined in the "contract".

The "contract" can be amended through the same procedures when the counselor and the client agree it is necessary. This might be done when it was not possible for the counselor or the client to complete the "contract" or when new information or events not controlled by the counselor or the client occur.

Since the Individualized Written Rehabilitation Program (IWRP) has been initiated into the rehabilitation process, some aspects of contractual counseling are now part of the case procedure. If contractual counseling is used from the beginning of the rehabilitation process, it may be easier to implement an IWRP. This may also be a more effective way of dealing with certain types of rehabilitation clients. It provides a good method of case management by forcing the counselor to plan his services.

The University of Arkansas Rehabilitation Research and Training Center has developed a training program for personal/social adjustment using a refinement of such contractual counseling techniques. This training program is for use in a group counseling situation. (An abstract of the Arkansas program is contained in another article in this edition of the Research Review.) The Research and Training Center is also exploring the possibility of a research project to develop these techniques for use in individual counseling.

Randall B. Scott, Research Utilization Specialist, prepared this explanation of contractual counseling. Additional information on the subject will be provided in the next issue of the Research Review. Requests for further details should be mailed to Randall B. Scott, Texas Rehabilitation Commission Central Office, 7745 Chevy Chase Drive, Suite 102, Austin, Texas 78752.

Special Olympics Boost Morale of Staff/Clients

As many of you know, "Three Days in May" means the Special Olympics held in Austin on May 28, 29 and 30. I would like to share with you the wonderful experience of attending the Special Olympics.

At 7:00 a.m. on the drizzling morning of May 28, two girls, six boys, two coaches, two chaperones and one bus driver left the Willows Unit at Vernon Center North aboard a big yellow school bus. We stopped at Vel'Mont Halfway House to add to our group one girl and one boy who had left the Willows Unit only the week before the trip. The next stop was the University of Texas at Austin where we were to spend three days of excitement, enthusiasm, competition and a little heartbreak.

After eight hours (it didn't seem that long because we had so much fun on the bus), we arrived at Jester Dormitory where we would be living during our stay.

We stood in a long registration line for about thirty minutes only to find we were one of many registrants who had what was termed as "problem registration". We had to move to another line and stood there approximately one hour more. Finally, we gathered our luggage, the T-shirts that had been given to us, our contestants and started for our rooms.

We went to dinner and then to Memorial Stadium for the opening ceremonies of the Special Olympics and the lighting of the torch. Tears flowed freely when that happened.

In a line next to us were children with hearing losses. The Willows' students asked what those children were doing with their hands. I explained that one of their handicaps was that they could not hear, but they compensated by talking with their hands. I'd like for many of the people who think the mentally retarded can't learn to have seen those young persons using sign language with such expertise.

Later that evening, an adventure movie in the dorm was attended by the hundreds of young contestants. At 10:30 p.m., the kids bedded down and the coaches attended a meeting during which we were briefed about coming events, what was expected of us and what we could expect from the Special Olympics staff. At midnight, we were able to conclude the day.

On Thursday morning, we were up at six o'clock and had breakfast at 6:30 a.m. By 7:30, we were on the field getting ready for the first events scheduled for 8:00 a.m. Things were going very smoothly when the weather interrupted our activities. It began to rain and rain and rain. The morning events were canceled and rescheduled for 1:00 p.m. We had another coaches' meeting and were told that the dance scheduled for that evening would have to be eliminated. Events would have to be run late into the night to make up for the time lost to the rain. Our group finished at 11:45 p.m. It had been an 18-hour day for us and we were very tired, but still enthusiastic.

At this point, I must include one heart-warming incident. During the 220 yard dash for 10-12 year old girls, five contestants were running around the track. Four of the girls finished. One little girl was halfway around the track but had decided to quit. She was so very tired and disappointed that everyone else had already crossed the finish line. Why should she keep going? The crowd of people in the stands understood how she felt. They wanted to encourage her. The people began to applaud. The little girl looked up and

started to run again. Then she lost hope and stopped. The crowd cheered for her. This happened two more times. She finished! Although she was exhausted and discouraged, she completed the race. She knew she could do it, especially since everyone had confidence in her.

That's the way we must work with these children. If we have confidence a child can do a task, he will think, "Well, maybe I can do it!". He will try again and again until he succeeds. This philosophy is evident in the motto of the Special Olympics

Let me win.
But if I cannot win,
Let me be brave in the attempt.

On Friday morning, the Willows Unit sent five contestants into the finals in which they won one gold and two bronze medals. What a day that was! The excitement, the enthusiasm, the cheers! We had made new friends, developed confidence and acquired a sense of accomplishment.

Returning to Jester Dormitory, we packed our bags and went to the lobby to wait for our bus. That was at noon, but our bus didn't come until 4:00 p.m. The fuel pump had broken. That was a letdown, but everything can't be perfect. It was a long trip home because no one wanted to leave the Special Olympics.

Those "Three Days in May" were something we will never forget.

This report was submitted to the Research Review by Tisch Hicks, Rehabilitation Technician, Willows Unit, Vernon Center North. If you would like further details about the Special Olympics, you may write to Tisch at P.O. Box 1313, Vernon, Texas 76384.

Pretrial Probation Aids Alleged Public Offenders

Statistically, crime in all areas of the country has been increasing each year. Most criminal justice systems have proven to be limited in their ability to respond with speed and flexibility in attempting to administer justice in what was already an overburdened court.

There is a growing evidence that new programs utilizing community approaches to correction as alternatives to lengthy trials is one way of eliminating the burden on the courts. These extra-judicial programs not only help eliminate the backlog in court proceedings but also offer the court yet another alternative to imprisonment.

The project in Wichita Falls is a cooperative program of Extra-Judicial Probation (unofficial or noncriminal in procedure) for the handling of alleged adult offenders and involving the Grand Jury, Prosecuting Attorney, Defense Attorney, Court and Probation Officer. In cases involving alleged adult violators of misdemeanor or felony offenses, a program of probation, restitution, probation service fees, etc. is formulated, whenever possible, prior to the filing of a complaint or formal petition. This probation program provides that upon satisfactory completion of the terms and conditions stipulated in the

Extra-Judicial Probation Program, which will extend for a period of time not to exceed the time that is set forth in the statute of limitation for the alleged offense, the case will be dismissed. In addition, any violation of terms and conditions of probation will be reason for the filing of a complaint and petition followed by a trial in the appropriate Court of Record. Then, upon a finding of guilt, there could follow a commitment to a correctional institution to serve the full sentence prescribed for such offense (Grant, 1974).

The basis for this project rests upon the generally accepted concept of human dynamics; i.e., the higher one raises the value of the incentive, the greater the motivation for positive changes within the individual who is involved. Such a procedure hopefully will afford the alleged offenders an opportunity to redeem themselves with minimum loss of self-esteem and prestige, yet will not compromise the rights of any injured party who may be involved and will enable the prosecuting attorney and/or the Courts to retain needed controls and jurisdiction.

Two hundred fifty-eight probationers in Wichita Falls have received probation services without being branded as convicted criminals due to this process of diversion prior to an appearance in criminal court. It would seem evident that, as opposed to a criminal court appearance or incarceration, a community-based program such as this could be utilized in an attempt to integrate the individual back into society. This approach permits the probationer to live in his own community and maintain most of his normal relationships with his family. While trying to attain normalcy in everyday living, the probationer is receiving control and guidance from his probation officer and assistive services from the Texas Rehabilitation Commission. Not all extra-judicial probationers are referred to the Texas Rehabilitation Commission, but, in 1973, it is estimated that of the two hundred fifty-eight individuals referred from the Extra-Judicial Program, one hundred were referred for TRC services.

It seems that this experimental program will be a more efficient, more economically feasible and more humane approach to the treatment of the offender. The principal social benefit derived from this project will be the immediate return of the individual to his family and his job. If the alleged offender is unable to return to employment and is eligible for TRC services, he may benefit from vocational training, on-the-job training, job placement assistance and other rehabilitation services.

There have been numerous pretrial intervention programs, but it appears that the program in Wichita Falls is one of the most successful. Tracy Kirkham, law student at the American University in Washington, D.C., was in Wichita Falls recently to study this Extra-Judicial Probation Project as part of her work on a Federally-funded study by the University's Institute for Studies in Justice and Social Behavior. She is examining alternatives to conventional adjudication.

In an interview with Wichita Falls Times staff writer Lois Luecke, Miss Kirkham commented on the informal approach used here in selecting probationers for the county program.

> "Miss Kirkham thinks the more informal approach used here in selecting probationers for the county program is commendable.
>
> 'The latitude is much greater, and the persons selected are selected for much more personal reasons,' she said.
>
> 'Most other states who have programs like this select their candidates by first checking the person's record against a set of predetermined criteria. . . The people are rejected on the basis of that criteria without having an interview with anyone,

and the people who are accepted on the basis of that criteria will then be sent to talk to a screening committee. . . then to a counselor, who will work with them.'

'In contrast, here in Wichita Falls, the decision to accept a person into Extra-Judicial Probation is generally made very informally by the District Attorney, and sometimes by the Grand Jury, and sometimes on the recommendation of Mr. [Frank] Grant [program director], and sometimes by the judges, based mainly on personal contact with the defendant.'

'This method of selecting people means on the one hand that the prosecution seems to be taking a chance with people who would be excluded from other projects, and yet, it [Wichita County's program] has a higher rate of rehabilitating than any other project that we have come across.'"

It would seem that, although this unique method of diversion is not a cure-all, it should be studied very closely to see if such a program can instill in probationers the capacity for lawful, productive behavior in the community.

This report was written by Jerry L. Hickman, Counselor, Texas Rehabilitation Commission, Wichita Fallas North District Office, 710 Brook, Suite 11, Wichita Falls, Texas 76301. Cooperative assistance on this project was obtained from Frank Grant, ACSW, Project Director, Wichita County Probation Department, Wichita County Courthouse, Wichita Falls, Texas.

Research Evaluates Drivers with Medical Problems

The Research Section of the Texas Rehabilitation Commission studied drivers with medical problems. Basic information was provided by the Texas State Health Department's Medical Advisory License Review Board. The purpose of this study was to determine the relationship existing between drivers with medical problems and motor vehicle accidents.

Data for a random sample of 3,998 drivers who had been referred to the Medical Advisory License Review Board by the Texas Department of Public Safety was acquired. Data analyses were performed for all variables including demographic characteristics, accident types and frequencies, types of operator's license, medical problems and the numbers of times a driver had been reviewed by the Medical Advisory Board. The Medical Advisory Board had previously reviewed pertinent information for each driver and had made recommendations to the Department of Public Safety regarding limitations of these operators' licenses.

Medical problems were grouped into ten general categories utilized by the Medical Advisory Board:

1. unexplained blackout
2. general physical/medical
3. cardiovascular
4. neurological
5. psychiatric
6. alcohol abuse
7. drug abuse
8. metabolic
9. musculoskeletal
10. vision

Medical problem categories with the highest distribution frequencies were cardiovascular problems (36.4%) and metabolic problems (22.4%). A very low proportion of drivers had visual problems (2.2%). This may indicate that the majority of drivers with visual problems had appropriate restrictions on their operators' licenses and did not come before the Review Board. Alcohol abuse accounted for a very small proportion (2.0%) of the medical problems, which could indicate that alcohol abuse may be undetected in many instances. The medical problem which showed the lowest frequency was drug abuse with only 0.7% of the drivers in this category.

An investigation of drugs abused by drivers referred to the Medical Review Board revealed heroin, marijuana and barbiturates were the most frequently abused substances. Only 29 of the 3,998 drivers included in this study were drug abusers. It was significant that 15 of these 29 drivers were heroin abusers. Marijuana abuse was recorded for five drivers and barbiturate abuse for four drivers. There was no drug abuse indicated for 3,963 (99.1%) of the drivers included in the study.

Demographic characteristics of the sample indicated males represented 68.4% of the total and females 31.6%. There was a very high proportion of white race members (94.9%) and a very low proportion of black (5.0%) and other races (0.1%). Age groups with the highest proportions were the 60 to 70 year olds (24.8%) and 50 to 59 year olds (24.6%). The age group of 17 to 30 year olds had the lowest proportion (10.6% of the total). It was interesting to note that 49.4% of the drivers were over 50 years old, a fact which could relate to the high proportion (36.4%) of cardiovascular medical problems. Drivers' chances of being referred to the Medical License Review Board greatly increased at 50 years of age and over.

Analysis of the distribution of original license types was made. The type of license most frequently issued to the drivers in the sample was an operator's license (73.4%). Almost 22% of the original licenses issued were commercial and only 4.5% of the drivers were issued chauffeurs' licenses. This may reflect stringent screening processes utilized by employers hiring commercial or chauffeur operators which could eliminate driver applicants with medical problems.

A large proportion (72.9%) of the referred drivers were located in Standard Metropolitan Statistical Areas (SMSA). The geographic distribution of drivers with medical problems was similar to that of the general population. According to the 1970 census, 74.1% of the total population of Texas resided in metropolitan areas. Drivers from rural non-SMSA areas accounted for only 9.2% of the total sample and 18% were from non-SMSA cities and towns of less than 50,000 population.

The number of accidents and number of times a driver had been reviewed before the Medical Advisory License Review Board were compared. A significant proportion (66.2%) of the drivers had no accidents. Only two drivers had as many as six accidents. An inverse relationship was found between the number of accidents and the number of times before the Medical Advisory License Review Board. Some 66.2% of the sample had never been involved in an accident, but only 2.9% had never had a Medical Board review. About 82.2% of the drivers had been reviewed once by the Board, but only 23.2% had been involved in one accident.

This research study also charted the license review opinions of the Medical Advisory Board. These opinions represented recommendations made to the Department of Public Safety regarding limitations of these operators' licenses.

In addition, figures were gathered to reveal the types of motor vehicle accidents of drivers in the sample, the number of accidents and whether or not the

driver received a citation as a result of the accident. The most frequent type of accident was motor vehicle with motor vehicle with a citation being issued. This type of incident occurred 614 times and had about a 20% chance of being repeated. Only two types of accidents, motor vehicle with motor vehicle and motor vehicle with parked vehicle occurred as many as five times.

In summary, the findings of this study showed over one third of the drivers with medical problems had cardiovascular trouble and almost one half were over 50 years of age. There was a low incidence of alcoholism (20%) and practically no drug abuse (0.7%). Males represented 68.4% of the total sample and females 31.6%. Almost 95% of the drivers in the study were white and 5% were black. A significant proportion (66.2%) of the drivers with medical problems in the sample had been involved in no motor vehicle accidents. The type of accident which occurred most frequently (15.4%) for these drivers was motor vehicle with motor vehicle with a citation being issued. Data indicated that drivers with medical problems had no more motor vehicle accidents than did drivers without medical problems in the general population.

The preceding excerpts, sometimes paraphrased, were taken from the Study of Drivers with Medical Problems (November 1974) prepared by Carol J. Whitcraft, Ph.D., and Earlene Call. A complete copy of the report and additional details may be requested by writing Dr. Whitcraft at the Texas Rehabilitation Commission Central Office, 7745 Chevy Chase Drive, Austin, Texas 78752.

Oklahoma Service Outcome Measurement Is Analyzed

The Service Outcome Measurement (SOM) Project grew out of increasing concern for accountability and program evaluation coupled with the awareness that no evaluation, regardless of the degree of sophistication, can be any better than the outcome measure on which it is based.

Although the present closure system has been acknowledged as being inadequate, it persists as the major outcome measure in Vocational Rehabilitation. The SOM Form was designed as an administratively feasible alternative and/or supplement to the present closure system to measure the outcome of Vocational Rehabilitation Services. Previous articles in the Research Review have summarized the results of the field test of the Service Outcome Measurement Form and have covered the reliability study, factor analytic study and case difficulty phases of the field test. This article reports further testing of the SOM Form as a measure of client change in a pretest-posttest design.

Clients (N=1820) pretested during the case difficulty phase of the study were posttested using the SOM Form either at case closure or one year after the pretest if their cases were still active (N=1395).

The measurements of client change were derived by subtracting the posttest scores from the pretest ones. These scores were used in analysis. In keeping with the goal of administrative feasibility, it was felt that validity must be shown for these measures of client change. This would permit the results to be utilized by agencies without sophisticated data processing support.

T-tests were run for the criteria and all scales to insure the changes indicated by the scores were significantly different from zero. The raw change

scores were then correlated with counselor ratings of physical change, change in social skills for the work setting, change in personal adjustment and rankings of the clients in terms of benefits received from Vocational Rehabilitation.

Total scores were computed two ways; the first utilized the Form as originally designed and the second used only those scales indicated by the previous factor analysis. The correlations of the total change scores with the four criteria are as follows: the original SOM Form Total Change Score correlated 16 with physical change, .36 with social skills change, .36 with personal adjustment change and .33 with benefit rankings. For the Factored Form Total Change Score, the correlations were .15 with physical change, .35 with social skills change, .35 with personal adjustment change and .31 with benefit rankings.

In addition to overall correlations, scores were analyzed for the stability of the relationships between the change scores and the change criteria. The data was divided into subgroups by state, age, race, sex, marital status, primary disability, previous agency contact and referral source. The demographic subgroups were then used in analysis. The only time either total change score had a significantly different subgroup regression coefficient for the eight breakdowns was when the data was divided by marital status subgroups and the dependent was change in social skills. In this case, statistics indicated two overlapping subsets of regression coefficients; one subset contained married, widowed, divorced and separated clients and the other subset contained widowed, divorced, separated and never-married clients.

The Service Outcome Measurement Form has now been tested in the field for reliability, internal consistency and against seven different criteria measures of case difficulty and client change. The SOM Form has held up well throughout the extensive testing. This is not to say the Service Outcome Measurement Form is the final answer to outcome measurement, but it is a solid start and a base from which improvement can be made.

The preceding summary was sent to Research Utilization personnel by W. J. Westerheide, Lowell Lenhart and M. Clinton Miller III. Counselors interested in further details about the statistical computations should address their questions to Mr. Westerheide at the Department of Institutions, Social and Rehabilitation Services, P.O. Box 25352, Oklahoma City, Oklahoma 73125.

Counselor Urges Planning for New Responsibilities

Counselors often have a difficult time being or at least acting like professional rehabilitation counselors. Too often we can lose sight of our goals and become bogged down in a maze of paper work, personal problems and individual prejudices.

The time has come when, if our professional responsibilities are not priorities, we may become stifled and stuck in the security of routine casework. We may also be leaving ourselves open for agency and legal repercussions and lawsuits brought against rehabilitation counselors by their clients.

In addition, we must consider the present metamorphosis of vocational reha-

bilitation. The Executive Director of the National Rehabilitation Association, E. B. Whitten, informed counselors gathered at the Southwestern Regional NRA meeting that in seven to nine years the practice of vocational rehabilitation will not even be similar to that which we know today. An indication of the direction in which vocational rehabilitation is moving is represented by our new Individualized Written Rehabilitation Program. Counselors are holding clients accountable for their part of the IWRP. In addition, clients will now be holding their counselors responsible for the fulfillment of the agency's part of the agreement. These modifications in human development services are changing the counselor-client relationship from a patronizing to an equal status. In the future, the counselor's role will require greater responsibility and, with that responsibility, increasing accountability.

INDIVIDUAL PROGRAM EVALUATION

What can each of us do to become more effective counselors within the Commission? What can we do to prepare for the coming "Future Shock" in our profession? This shock will not come during the next generation; it will occur in 1980.

One source of increased "counselor accountability" and preparation for the future might be "individual program evaluation". Agency program evaluation serves an important role which cannot be found elsewhere and should not be "played down", but what about a procedure for "individual program evaluation"? This procedure is being used experimentally by rehabilitation counselors (rather than by agencies) in many states.

If we really want to do a better job to serve our clients, what about having a fellow counselor evaluate our caseload? Each counselor knows most of his assets as well as most of his liabilities, but we also have blind spots. As time passes, the blind spots grow larger. Any counselor should be able to permit a co-worker to visit for several hours to make notes about counselor strengths and weaknesses, praise good placements and constructively criticize inadequate programs. The greatest benefit of "individual program evaluation" will be to the two counselors who participate in the process. Both the evaluating and evaluated counselors will have participated in a learning experience. "Individual program evaluation" could provide each counselor with the opportunity to improve professional responsibilities and become more effective in the management of his own caseload. The adoption of such a procedure could indicate the counselor's acceptance of the increasing accountability being directed to him by State and Federal administrators and the clients on his caseload.

IMPROVED COMMUNICATION

Self-education for professional improvement by means of "individual program evaluation" is commendable, but what can a counselor do to surmount mountains of paper work and delve through the protocols for communicating with many levels of administrators? I am a counselor. I realize the necessity and importance of administrators and appreciate their dedication to their responsibilities. Nonetheless, I tend to view administrators as "supportive staff". Administrators must be aware of the needs of counselors or everyone will have problems.

This year the Texas Rehabilitation Commission has stressed the development of improved communication. As a result, many informative memoranda have

crossed my desk. Administrators have authority, but counselors have responsibility. Counselors should have taken the lead in developing improved communication. What would happen if each counselor started writing letters and memoranda of professional concerns to his supervisor and regional director? Not demands or gripes - but concerns. Counselors can open up channels of communication.

It occurred to me not long ago that it may be difficult for a single counselor to affect agency policy. It also occurred to me that those counselors who "ride the tide" or "blow with the wind" do an injustice to the agency and fellow counselors. In the long run, these counselors do even greater injustice to their clients. When a client really communicates (opens up) with his counselor, he moves some of his responsibility (genuine feeling) to the counselor. Is it any different when a counselor expresses viewpoints and concerns to his supervisors? There is an old saying, "He who has the responsibility (client services) is held accountable (evaluated) by he who has the authority (administrators)." In the human development services process, counselors throughout the United States are being held legally responsible for their actions or inactions because they have not shifted some of their responsibilities (communication) to those in authority. Thorough documentation cannot take the place of communication. It is the duty of the administration to keep counselors informed of new legislation and policies. It is the job of the counselor to keep the administration informed of client needs and feelings.

P R O F E S S I O N A L C E R T I F I C A T I O N

The Texas Rehabilitation Counselors Association is one of the most meaningful ways of expressing individual professional concerns. A professional approach to rehabilitation counseling does not mean a cold or academic approach. It means a well-planned, meaningful and effective process.

Counselors have the responsibility to be aware of and involved in client needs. This responsibility is spelled out for us in our code of ethics which, by the way, should hang on every office wall. This responsibility makes each counselor accountable for his own "individual program evaluation" and effectiveness. The counselor is also accountable to and responsible for his supervisors. If counselors do not keep supervisors informed about client needs and counselor concerns, how can administrators "keep in touch with the field".

Part of the emphasis of the Certified Rehabilitation Counselor program is to make counselors professionally accountable for the growth of their own profession. If rehabilitation counseling is a profession, then we are responsible for our own professional growth. We are accountable for how well we fulfill that responsibility. If we, as counselors, refuse this responsibility, then the certification process has been a sixty-five dollar farce.

Grassroots counselors are responsible for the rehabilitation of clients, individual and professional growth and, to an undetermined degree, influencing the direction of the philosophy of vocational rehabilitation. The Texas Rehabilitation Commission allows ample freedom for counselors to individually improve their particular process of providing rehabilitation services. For those of us who are certified rehabilitation counselors, this professional growth has evolved from a freedom into a professional responsibility.

P R O F E S S I O N A L R E S P O N S I B I L I T I E S

The future of vocational rehabilitation is so dynamic that counselors cannot determine its aggregate direction. Our choice is how we choose to provide human services most effectively during major philosophical and legislative changes.

Our professional ethics demand that we do not wait for an "agency" to direct our growth, evaluation or effectiveness. These ethics require that we be aware of and take action on our professional needs and the needs of our clients.

As individual counselors, we have the necessary resources to improve client services, agency communication and professional growth. Whether or not we accept these responsibilities is an individual as well as a professional decision. Irregardless of whether counselors accept these responsibilities, we, both individually and as a profession, are being held accountable for them.

This article was prepared for the Research Review by Lorrin Walker, Counselor, Vernon Center North, Holly Unit, P.O. Box 1313, Vernon, Texas 76384. Lorrin would like to receive readers' comments about this article.

Field Evaluation of Research Review Is Completed

Research Utilization staff members have compiled the responses to the Evaluation of the Research Review questionnaire which was included as a part of the Winter 1975 (Vol. 2, No. 2) edition of the Research Review. The results are as follows:

106 readers responded to the questionnaire - 54 counselors, 11 supervisors, 2 psychologists and 39 "others"

99% of the respondents felt the Research Review provided them with information which helped them to better perform their job duties (Only one person strongly disagreed)

99% of these readers would like to see the Research Review continued

99% of these evaluators felt that Research Review articles are of professional interest to them and agreed that the Research Review provides them with information they do not receive from other sources

94% of the respondents liked the format and writing style

85% of these readers wanted more opportunities for feedback from the field

81% of these evaluators have requested library materials which were listed in the Research Review

80% of the respondents would like for the Research Review to publish more articles on research at R&T Centers

72% of these readers would like for the Research Review to contain more abstracts of research reports.

Respondents indicated interests in all areas of rehabilitation. It was not possible to draw any conclusions from these particular responses. Virtually all of the 106 readers wanted more information about "the severely disabled", a category which can include almost all disabilities.

In order to provide an opportunity for additional feedback, RU staff have included another evaluation form in this issue. Please check your responses and put the questionnaire in the mail! It's one of the ways through which we can improve our services for you.

The results of the winter survey have been divided into responses by counselors, supervisors, Central Office staff, non-TRC personnel and grand totals. A complete list of comments is also available. For your copy, please write Research Utilization Section, Texas Rehabilitation Commission Central Office, 7745 Chevy Chase Drive, Suite 102, Austin, Texas 78752.

Library Services Are Provided for the Handicapped

Counselors should be aware that special library services are available for the visually-impaired and the physically handicapped. These services, provided by the Texas State Library, can give many hours of entertainment and instruction to persons who cannot read without assistance.

The Texas State Library is part of a network of regional libraries for the blind and handicapped which is administered by the Library of Congress. Since 1931, Division for the Blind and Physically Handicapped of the Library of Congress has been supplying books in braille, on sound recordings and through other forms to eligible Americans.

In order to qualify for these special services, a person must meet specific eligibility requirements. In greatly simplified terms, if an individual cannot read a normal-sized book or hold it or turn its pages, he most likely fulfills the eligibility criteria.

In addition to library materials, the Texas State Library also loans reading aids (such as magnifying glasses), "talking book" machines (record players) and cassette tape players. In order to share these devices with handicapped Texans, library personnel work closely with Texas Commission for the Blind staff. The TCB employees handle the mailing of "talking book" and cassette tape machines, while the library staff mail the Library's materials. No postage is required for the mailing of the machines or the materials.

The reading aids are State property. The machines and their accessories are Federally-owned. "Accessories" may include remote control units, pillow phones, head phones, etc.

The library collection is diverse and includes fiction, nonfiction, academic texts, musical scores, magazines, etc. All library items are in complete and unabridged form. The State Library's division of the blind and handicapped has a new tape duplicating center which should provide for even greater availability of materials on open reel and cassette tapes.

The Texas State Library counts over 20,000 active readers throughout the State who are visually-impaired and physically handicapped. Over 690 Texas institutions (nursing homes, schools, etc.) make use of these special services.

Library staff mail out approximately 3,000 books each working day. During 1974, librarians mailed out over 278,000 books and magazines in various forms to visually-impaired and physically handicapped "readers".

So...the next time you meet a handicapped homemaker who could benefit from a cookbook in extra-large type...or if you know of a homebound client who could be cheered by having access to murder mysteries in record form, please have them contact the

Texas State Library
Division for the Blind and Physically Handicapped
P. O. Box 12927
Capitol Station
Austin, Texas 78711

This Division of the Library, which is open from 7:30 a.m. - 5:00 p.m., also has a toll free number for its patrons to use 800 - 292-9605.

Final Report of 'Project Expedite' to Be Printed

In the Fall 1973 edition, the Research Review featured an article on PROJECT EXPEDITE, an SRS-funded Research and Demonstration Grant Program based on the belief that the rapid delivery of comprehensive services is the prime catalyst for engaging and holding clients in the vocational rehabilitation process. That article provides a thorough background for the following summary of the Project's activities. This summary has been prepared from the PROJECT EXPEDITE Final Report which will soon be printed.

After experiencing the usual problems associated with new organizations, PROJECT EXPEDITE, in a reasonably short period of time, matured into a smoothly-operating, highly goal-oriented diagnostic facility. The experimental Houston unit accepted all types of referrals from itinerants in town for only a few hours to amputees needing repairs for prostheses, from applicants without food and shelter to those with less urgent needs. The experimental unit provided quality diagnosis quickly and at a modest cost per procedure. Counselors who utilized the unit's services rated the concept of fast, comprehensive, package-type diagnosis highly and, in general, endorsed the Project.

It did not take long, however, to realize that not all referrals were good candidates for rapid diagnosis. Some referrals did not have the mental stability to sustain the rapid pace and others sometimes quietly "dropped out" without any apparent reason. Some referrals stated in advance that they could not spend one or two entire days in diagnosis and requested that the evaluation be spread out over a period of time. Although such cases were in the minority, PROJECT EXPEDITE evaluators had to be ever mindful of them.

Results revealed that the PROJECT EXPEDITE experimental group had slightly more rehabilitated closures than a comparative control group, but failed to produce a substantial increase as had been predicted. Experimental group referrals were superior to control group counterparts in terms of employment stability and fewer follow-up procedures were required. The two findings seem to be related and appear to be the results of the fast, comprehensive diagnostic technique.

A search for plausible explanations for the results which did not meet projected expectations produced a number of possible causes.

Some observers criticized the Project's use of "surrogate" counselors in the diagnostic unit. They pointed out that early involvement of the permanent

counselor would customize the case both from the standpoint of the client's needs and the individual counselor's unique mode of case management. This point of view holds that, by eliminating the surrogate or "middleman", the client quickly becomes identified with his counselor in a relationship that is relatively free of third party opinion and, therefore, the case should progress more quickly and economically. While recognizing that this factor could have played a role in the results, it should be pointed out that the control group also used surrogates (interviewers), although to a lesser degree.

A second internal factor, previously mentioned, which may have had an effect on the results was the group of referrals (approximately 10% of the intake) whose needs and personalities did not fit the mode for rapid diagnosis and for whom such a unit was inappropriate. These referrals were served satisfactorily, but the inclusion of these people in the experimental unit tended to lower the overall effectiveness rating of the unit.

Several external factors were also examined in order to provide a better understanding of the experimental setting. The degree of effect, if any, is not known.

- A citywide expansion and decentralization process took place during the Project. This resulted in numerous personnel transfers from the Project. Often it was necessary to transfer counselors just after they became accustomed to the system of faster diagnosis. This led to some cases being transferred to a new or another counselor. This may have had somewhat of a neutralizing effect on the faster diagnosis coming out of the experimental unit.

- The necessity for occasional fiscal austerity measures may have had a dampening effect on experimental group clients who had earlier been oriented to the idea of expeditious service.

- Heavy demand for vocational rehabilitation services sometimes made it difficult for counselors to see experimental unit cases as rapidly as they had been seen in the experimental unit. This may have tended to break the rhythm of case movement.

- Faster diagnostic services became possible for the control group when private psychologists established offices in the Project building and offered faster reporting services. One group of control group counselors had access to the services of an agency psychologist. These developments tended to reduce the advantages of the experimental unit.

- Accustomed to having free access to all agency facilities in assisting clients, some counselors may have found the research limitations imposed by random selection difficult to accept. In other words, counselor attitudes may have been affected by the one-way flow of clients. This process permitted the experimental unit staff to send cases to the counselors, but the counselors were precluded from referring cases to the unit at their discretion.

Investigators also found that the case folders for control group referrals

took longer time to develop. Client perseverance was required during this waiting period. As a result, the counselor often had a longer period of time in which to consider a case and become better acquainted with the client. In a sense, the waiting period was seen as a test of motivation. Those persons who "survived" the waiting period usually were assessed as better candidates for successful rehabilitation.

In one of the first tests of the RIDAC (Rehabilitation Initial Diagnosis and Assessment of Clients) concept, the Houston Project was seeking to accomplish two objectives:

(1) introduction of an innovative approach to vocational diagnosis, emphasizing speed and comprehensiveness and

(2) assessment of the long range effects of this approach in terms of economy and improved client services.

Both objectives were fully reached. For the most part, the study of long range effects did not produce the expected findings, but it did produce valuable information and new hypotheses regarding the dynamics which come into play when the traditional diagnostic process is modified. The investigators are confident that a new diagnostic unit, modified to take advantage of the knowledge obtained in this research, would prove more effective in the areas of economy and client services.

This summary was prepared from excerpts taken from the Final Report of PROJECT EXPEDITE which was authored by M. H. Goldston, Jr., Project Administrator, and Robert J. Hefley, Project Coordinator. It is anticipated that the report will be printed by October. For further information, please contact the Research Utilization Section, Texas Rehabilitation Commission Central Office, 7745 Chevy Chase Drive, Austin, Texas 78752.

Survey Lists Rehab Resources for the Mentally Ill

The CSAVR Program Development Committee, in concert with Rehabilitation Services Administration staff, has worked for the past year to develop the document entitled Psychiatric Rehabilitation. It is hoped that this reference will be of assistance to vocational rehabilitation agency directors and staff as they analyze and plan the best possible services and programmatic approaches to meet the needs of the severely handicapped mentally ill.

The purpose of the document is to update research findings and program development implications resulting from a survey of forty-four states, the District of Columbia and two territories. Also included are recommendations for program development based on survey results and three state interagency agreements with respective mental health systems.

A quick analysis of the state surveys indicates that many states find it difficult to support and expand services to the mentally ill because of one or a combination of the following reasons:

- Lack of resources to pay for services or hire specialized staff
- Lack of existing facilities, services or programs
- Lack of staff expertise
- Lack of constructive interface with the mental health system
- Problems related to a shift presented by deinstitutionalization and transition to community-based mental health systems.

It is important to note that some states have successfully attacked and solved some of the above difficulties. A review of these approaches might be helpful to state agency staffs as they scrutinize and review the best program development stategies to meet the needs of severely handicapped mentally ill individuals.

A few examples of state successes are:

- Joint planning between vocational rehabilitation and mental health staffs at state, regional and catchment area levels
- Participation of vocational rehabilitation staffs or units in treatment teams at staff meetings, etc.
- State vocational rehabilitation agencies cooperating with mental health and other agencies to seek and expand services utilizing all available resources
- Staffing patterns planned around a network of sources of referrals and including substantial outreach capabilities
- Development of prevocational and evaluation programs within day treatment and other community mental health center activities
- Initiation of new approaches in working with the severely disabled mentally ill
- Acceptance of realistic goals for the severely disabled mentally ill in terms of length of time clients will need service, multiplicity of services required, level of outcome and need for follow-up.

A copy of this report is available in the TRC Library. Deputy Commissioner Vernon M. Arrell and Program Specialist John Wylie worked diligently to prepare the Texas portion of the national survey.

Additions to Film Collection

Since the last listing of the film collection of the Texas Rehabilitation

Commission Library, four additional films have been acquired.

1. *A Day in the Life of Bonnie Consolo* - Bonnie is an American housewife who drives her car, bakes bread, cans vegetables and performs the other tasks required to run a home and be a mother. Bonnie Consolo was born without arms, yet she does not consider herself disabled.

2. *Try Another Way* - Marc Gold, Ph.D., depicts new approaches in teaching the profoundly mentally retarded to perform work tasks. In the film, two profoundly retarded workers learn to assemble a bicycle brake.

3. *Struggle for Los Trabajos* - The presentation addresses the problems of racial discrimination in employment and discusses Equal Employment Opportunity efforts to eliminate this discrimination.

4. *Choosing a Job* - This film indicates the diversity of employment opportunities open to candidates for "office jobs". It shows the job traits and skills required for these positions and emphasizes the importance of seeking professional help, perhaps from a school counselor, to make a career decision.

Sample of Library Resources

5. *Goal Planning in Mental Health Rehabilitation*. Houts, Peter S. and Scott, Robert A.

6. *Revolution in Counseling - Implications of Behavioral Science*. Krumboltz, John D., editor.

7. *Behavior Modification in the Natural Environment*. Tharp, Roland G. and Wetzel, Ralph J.

8. *Behavioral Counseling - Cases and Techniques*. Krumboltz, John D. and Thoresen, Carl E.

9. *Principles of Behavior Modification*. Bandura, Albert.

10. *Applying Behavior Contracts to Chronic Problems*. Hackney, Harold.

11. *The Contract as a Counseling Technique*. Thomas, G. Patience and Ezell, Betty.

12. *Behavioral Objectives - The Key of Meaningful Client Rehabilitation Plans*. Barton, Everett H., Jr.

13. *Assigned Versus Participative Goal Setting with the Educated and Uneducated Woods Workers*. Latham, Gary P. and Yukl, Gary A.

14. *Integrating Humanism and Behaviorism Toward Performance*. Smith, Darrell.

15. *A Diary of Self-Modification.* Goldiamond, Israel.

16. *How to Control Yourself.* Goldfried, Marvin R. and Merbaum, Michael.

17. *Contingency Contracts with Truants.* Brooks, B. David.

18. *Ethical and Legal Considerations in Guidance.* Huckins, Wesley.

19. *The Mental Health of Rural America: The Rural Programs of the National Institute of Mental Health.* Segal, Julius, Ph.D., editor.

20. *Diversion From the Criminal Justice System.* Shah, Saleem A., Ph.D.

21. *Preventive Vocational Rehabilitation.* Wright, Logan, Ph.D.

22. *The Evaluation of Vocational Development of Deaf Young Adults: Final Report.* Guilfoyle, George R., Ph.D., et al.

23. *The Training of Retarded Adolescents and Adults in Nonverbal Symbolic Picture Logic.* Milgram, Norman A. and Wolfgang, W. Reidel.

24. *Behavior Change Through Self-Control.* Goldfried, Marvin R. and Merbaum, Michael.

25. *Manpower and Vocational Education in Texas.* Mullins, Terry W. and Guerra, Roberto S.

26. *The Mental Health of Urban America: The Urban Programs of the National Institute of Mental Health.* National Institute of Mental Health.

27. *PADEC: An Evaluation of an Experimental Rehabilitation Project.* Berkowitz, Monroe and Anderson, Merilee.

28. *Toward Effective Counseling and Psychotherapy: Training and Practice.* Truax, Charles B. and Carkhuff, Robert R.

29. *Modern Mental Measurement: A Historical Perspective.* Lyman, Howard B.

30. *School Testing Programs.* Bauernfeind, Robert H.

31. *Controversial Issues in Testing.* Barclay, James R.

32. *Ego Psychology in Counseling.* King, Paul T. and Neal, Robert.

33. *Family Consultation.* Fullmer, Daniel and Bernard, Harold W.

34. *The Initial Counseling Contact.* Perez, Joseph F.

35. *Psychological Influences on Vocational Development.* Zytowski, Donald G.

36. *Interpreting Guidance Programs to the Public.* McClary, George O.

37. *Criminal Registration Statutes and Ordinances in the United States - A Compilation.* Dreher, Robert H., J.D., and Kammler, Linda.

38. *Psychedelic Drugs: Psychological, Medical and Social Issues.* Wells, Brian.

39. *Underwriting and Rating for Life and Health Insurance Coverage of Persons with Epilepsy: Report of a Study Conducted Under a Research Grant From the Epilepsy Foundation.* Epilepsy Foundation of America.

40. *Contribution of the Teamwork Approach to the Rehabilitation of the Facially Disfigured.* Converse, John M., M.D.

41. *Evaluation of Several Commercially Available Automotive Hand Controls.* Hyman, William A. and Newell, Paul H., Jr., Ph.D.

42. *Motivation and the Disadvantaged Trainee: A Manual for Instructors.* U. S. Bureau of Adult, Vocational and Technical Education.

43. *Social Disadvantagement and Dependency: A Community Approach for the Reeducation of Dependency Through Vocational Rehabilitation.* Craddock, George W.

44. *Diabetes and Blindness: Implications for Rehabilitation Services.* American Association of Workers for the Blind.

45. *Facts About Diabetes.* American Diabetes Association.

46. *Handbook of Correctional Psychiatry.* Skelton, Douglas, M.D., et al.

47. *Service Needs of Paraplegics and Quadriplegics.* Spangler, Donald P., Ph.D.

48. *Role of Vocational Evaluation in Alcoholic Rehabilitation Program.* Kelser, Joseph P., M.D.

49. *Annotated Bibliography of Placement Materials.* Texas Rehabilitation Commission.

50. *Selective Placement: Hiring the Handicapped According to Their Abilities.* U. S. Civil Service Commission.

51. *Placement Process in Vocational Rehabilitation Counseling.* Thomason, Bruce, editor.

52. *Recommended Standards for Closure of Cases: A Report From the Study Group on Uniformity of Standards for Termination of Services to Clients.* Little, Curtis O.

53. *Intensive Follow-Up Services to Marginal Workers.* Arkansas Rehabilitation Service.

54. *Long-Range Planning: The Executive Viewpoint.* Warren, E. Kirby.

55. *Changing Expectations: A Program of Rehabilitation for the Psycho-Socially Disabled.* Craddock, George W.

56. *Self-Directed Behavior: Self-Modification for Personal Adjustment.* Watson, David L. and Tharp, Roland G.

57. *Self-Control: Power to the Person.* Mahoney, Michael J. and Thoresen, Carl E.

58. *Dummy: There is Probably No Other Case Like It In the Annals of Anglo-Saxon Law.* Tidyman, Ernest.

59. *Mental Retardation: A Handbook for the Primary Physician.* American Medical Association.

60. *Maxillofacial Restoration.* University of Texas at Houston, M. D. Anderson Hospital and Tumor Institute.

61. *Psychiatric Diagnosis, Therapy and Research on the Psychotic Deaf.* Grinder, Roy R., editor.

62. *Motor Aptitude and Intellectual Performance.* Ismail, A. H.

63. *Comparative Study of First Offenders and Recidivists.* Mabry, James C.

64. *Recreation and Mental Retardation.* Avedon, E. M.

65. *Investment Theory and Selection of Vocational Rehabilitation Clientele.* Hills, William G. et al.

66. *Severe Disabilities.* Hardy, Richard E., Ed.D., and Cull, John G., Ph.D.

67. *Definition of Role and Functions of the Rehabilitation Counselor.* National Rehabilitation Counseling Association.

68. *Foster Family Homes for Adults.* Roecker, Mayeen.

69. *Human Communication and Its Disorders: An Overview.* Cathart, Raymond.

70. *Significance of Respiratory Impairments in Hemiplegics.* Haas, Albert, M.D.

Library Materials

The previously listed library materials are available for your use on a loan basis from the Texas Rehabilitation Commission Library. They may be requested from the Research Utilization Office, Texas Rehabilitation Commission, 7745 Checy Chase Drive, Austin, Texas 78752.

Please include in your request the number which appears prior to the description of the material and the phrase "Spring/Summer 1975 Edition of the Research Review".

Library materials are loaned for a three-week period. They may be renewed by phone or memo only if there is not a waiting list for the data. Books may be requested for a second time by an individual only after the waiting list has been reduced.

Texas Rehabilitation Commission
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Austin, Texas 78752