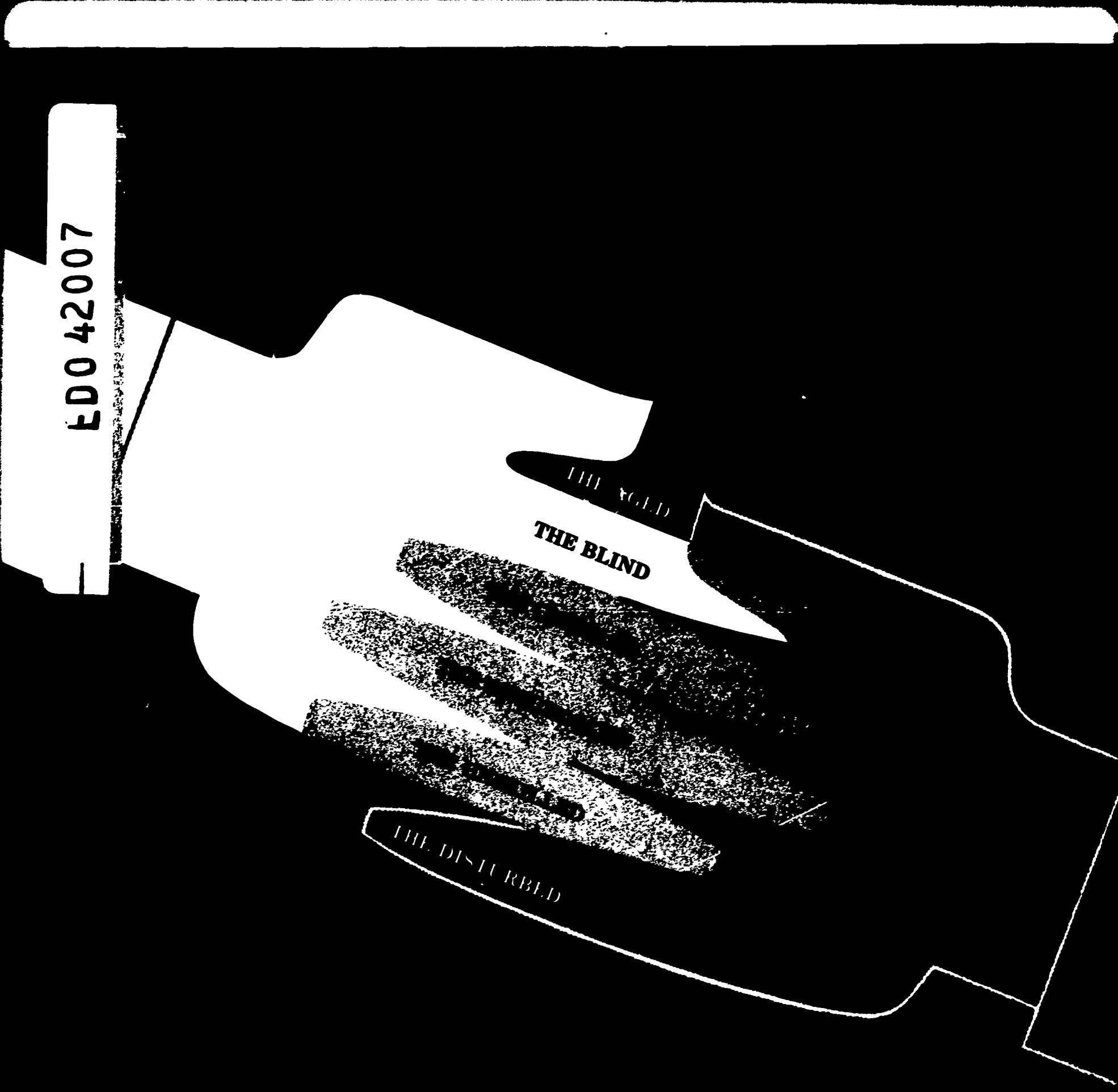
DOCUMENT RESUME

ED 042 007 VT 011 028

TITLE	Helping All the Handicapped; The Report of the Massachusetts Vocational Rehabilitation Planning Commission.
INSTITUTION	Medical Foundation, Inc., Boston, Mass.
SPONS AGENCY	Oregon State Univ., Corvallis. Div. of Vocational, Adult, and Community Coll. Education.; Rehabilitation Services Administration (DHEW), Washington, D.C.
PUB DATE	31 Oct 68
NOTE	222p.
EDRS PRICE	EDRS Price MF-$1.00 HC-$11.20
DESCRIPTORS	Disadvantaged Groups, *Handicapped, Job Placement, *Program Planning, State Federal Aid, *State Programs, *Vocational Rehabilitation
IDENTIFIERS	Massachusetts

ABSTRACT

This report by the Planning Commission culminates 2 years of public hearings and the investigations of 10 task forces on vocational rehabilitation. A broader definition of the disabled, one which includes the disadvantaged, is gaining acceptance, resulting in the need for expanded rehabilitation programs. This study provides the necessary guidelines for that expansion. Principal recommendations among the 200 made by the Commission include: (1) administrative reorganization at both state and community level, (2) increased services on a regional level through cooperation of qualified agencies, (3) improved placement efforts, including sheltered employment, (4) extension of the architectural barriers board to cover all buildings open to the public, (5) expanded services for the public offender, (6) adjustment to technological change, (7) strengthened research units, and (8) increased male recruitment and training of personnel. (BH)



HELPING ALL THE HANDICAPPED

THE REPORT OF THE
MASSACHUSETTS VOCATIONAL REHABILITATION
PLANNING COMMISSION

DISCRIMINATION PROHIBITED — Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall, on the grounds of *race, color, or national origin*, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program *or activity* receiving Federal financial assistance." Therefore, all programs or activities receiving financial assistance from the Department of Health, Education, and Welfare must be operated in compliance with this law.

HELPING ALL THE HANDICAPPED

THE REPORT OF THE MASSACHUSETTS VOCATIONAL REHABILITATION PLANNING COMMISSION

THE COMMONWEALTH OF MASSACHUSETTS
VOCATIONAL REHABILITATION PLANNING COMMISSION
BOSTON, MASS. 02116

October 31, 1968

His Excellency John A. Volpe
Governor of the Commonwealth
State House
Boston, Massachusetts

Dear Governor Volpe:

On behalf of the members of the Vocational Rehabilitation Planning Commission, appointed in accordance with your Executive Order No. 50, dated May 4, 1966, it is an honor for me to present the Planning Commission's report.

During the past two years, the Planning Commission held public hearings in six major cities of the Commonwealth. More than 300 witnesses presented personal testimony or submitted statements. Public officials, state legislators, public and private agency directors, clergymen, professionals, representatives of labor and industry and members of self help groups were heard. Presentations made by, or on behalf of, the more severely physically disabled, public offenders, the mentally impaired, ghetto residents and the rural underprivileged were especially poignant.

In addition, the Planning Commission appointed ten task forces to consider major issues in vocational rehabilitation and to prepare recommendations. Hundreds of concerned citizens from all parts of the Commonwealth contributed a great deal of their time and energy to the exploration of all aspects of this complex problem.

Project staff reviewed the available literature on rehabilitation and consulted with professional and lay persons who added to their total knowledge and guided their efforts. Material from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education and Welfare in Washington and the guidance of their regional office in Boston proved most helpful.

We are on the verge of a greatly expanded definition of the handicapped to include the disadvantaged as well as the traditionally disabled. New combinations of human services and facilities, located in city neighborhoods and rural areas of greatest need will offer an opportunity for human resource agencies in state government to combine efforts, to pool funds and to coordinate programs for more realistic delivery of service. Consumers of services will become increasingly involved in the planning and delivery of services. This new dimension of rehabilitation, this vast expansion of services, will require expanded funding, more trained personnel, more facilities and an immense amount of dedicated effort.

I would like to convey to you the Planning Commission's gratitude for your own personal interest in our work. In addition, the opportunity to work closely with the Executive Office of Administration and Finance and its Office of Planning and Program Coordination in laying out the groundwork for administrative implementation of a continuing planning effort should serve to translate the Planning Commission goals and proposals into meaningful programs to help our handicapped citizens.

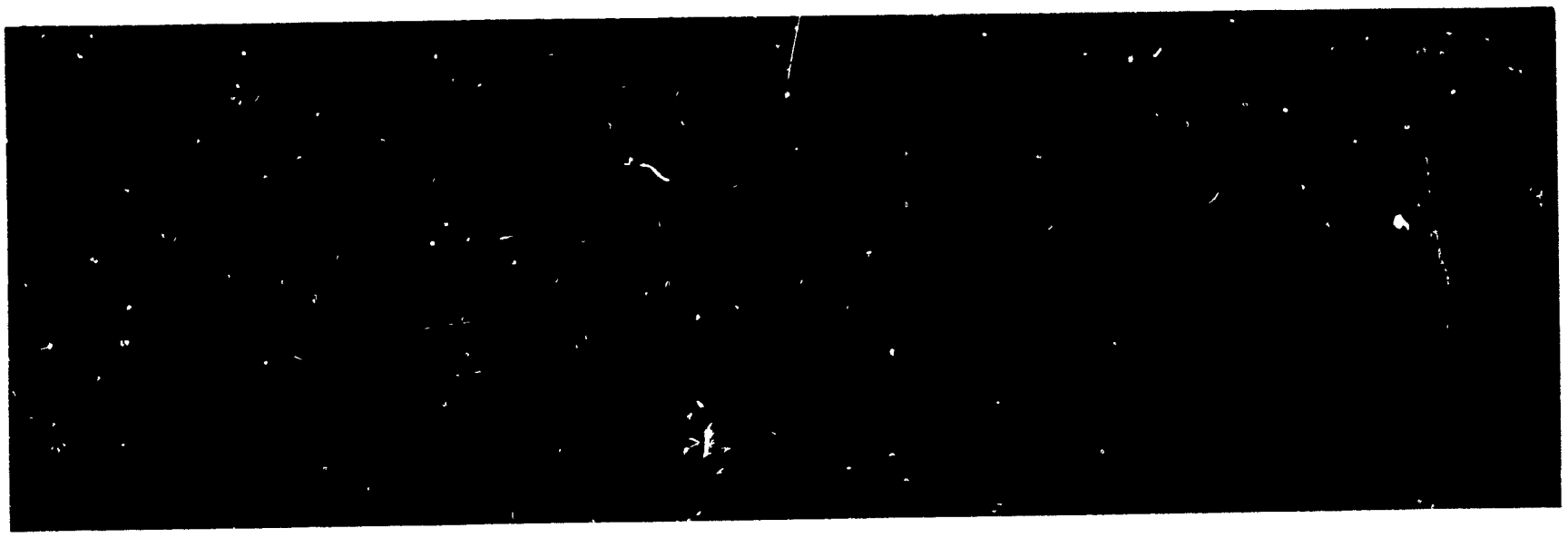
Respectfully submitted,

W. Scott Allan

W. Scott Allan
Chairman

[1]Until December 1966.
[2]Until May 13, 1967.
[3]Until January 31, 1967.
[4]From February 1, 1967.
[5]From December, 1966.
[6]Deceased

§Chairman
‡Treasurer
†Member, Executive Committee



ACKNOWLEDGEMENTS

Hundreds of citizens of the Commonwealth concerned with the problems of handicapped people and eager to help these individuals reach their full potential contributed innumerable hours to the work and report of the Vocational Rehabilitation Planning Commission. In acknowledging the participation and cooperation of all these participants, I do so as spokesman for the Planning Commission staff.

Our special emphasis concentrated upon delineating the potential for the unique contribution of rehabilitation philosophy and practices for disabled and other disadvantaged persons within the broader context of the spectrum of human services.

Responsibility for policy decisions and recommendations remained with the Planning Commission and its Executive Committee. Planning Commission members worked assiduously for common purposes, continually submerging special interests while striving for a unified approach. Governor Volpe's appointment of W. Scott Allan as Chairman of the Planning Commission assured statesmanlike and informed guidance to the project. Commissioner of Rehabilitation, John S. Levis and Commissioner for the Blind, John F. Mungovan and their staffs were unstinting in their cooperation and support in the work of the Planning Commission.

Complete cooperation was received from the Governor, his representatives, and all agencies related to the state rehabilitation program. Similar cooperation and interest was evidenced throughout by the leadership of the General Court and legislators, many of whom participated as members of the Planning Commission, task forces and at public hearings. We are especially pleased with the involvement of self help groups of handicapped people throughout the state, voluntary agencies, and individual disabled and disadvantaged persons.

Staff members were completely dedicated and worked tirelessly to gather and sift through findings and proposals. Although a fire in the Planning Commission office temporarily impeded its work, a spirit of team accomplishments overcame difficult working conditions.

Special thanks are extended to Dr. Harold W. Demone, Jr. who rendered dedicated and invaluable assistance as senior consultant to the Planning Project.

A word of thanks is also due the regional and federal staff of the Rehabilitation Services Administration who continually supported our efforts to devise innovative approaches for the rehabilitation of all handicapped persons.

Finally, we are indebted to the Medical Foundation, Inc. for administrative support above and beyond its contractural agreements in the best spirit of community service.

Edward Newman

EDWARD NEWMAN, PH.D. ..... *Executive Director*

WALTER F. STERN, PH.D ..... *Associate Director*

BERNARD G. GRAY, PH.D ..... *Research Director*

MELVIN E. COHEN, ED.D ..... *Program Development Director*

FRANK J. LASKI, LL.B. (Until Feb. 68) ..... *Legal Counsel*

C. DAVID HILBURN, LL.B. (After Feb. 68) ..... *Legal Counsel*

MARTHA WHITTALI ..... *Administrative Assistant*

ARLENE J. GOLDBERG ..... *Secretary*

HELENE LEVITZ ..... *Secretary*

[redacted]

LEONARD M. BLOKSB' . G, PH.D. ..... *Planning Associate*

BERTON S. FLIEGEL, M.S.S.S. ..... *Community Planning Director*

FRANKLIN B. FOGELSON, PH.D. ..... *Planning Associate*

RICHARD P. MELIA, M.A. ..... *Research Associate*

M. JANE WELSH, ED.M. ..... *Planning Associate*

ROSEMARY WHITING ..... *Planning Assistant*

[redacted]

HAROLD W. DEMONE, JR., PH.D. ..... *Senior Planning Consultant*

WILLIAM J. CURRAN, LL.M. ..... *Legal Consultant*

ALLEN D. SPIEGEL, PH.D. ..... *Planning and Editorial Consultant*

MARJORIE A.C. YOUNG, DR. P.H. ..... *Planning Consultant*

[redacted]

PETER C. COURTNEY, M.P.A.

KATHERINE J. WELLS, B.A.

JEFFREY P. LOWERY, ED.M.

PATRICIA A. WISOCKI, M.A.

[redacted]

ARTHUR ANDERSON, JR., B.A.

MARY GRACE BARON, M.A.

DAVID M. CORWIN, A.M.

SYLVIA G. FINK, M.A.

NANCY J. FOX

ANNE HEWITT, B.A.

JOSEPH JACOBSON, B.A.

CAROLYN KAPLAN

HARRY V. MACNEILL, B.E.

WILLIAM MANTZOUKAS, B.A.

BRUCE R. PARKER

MARK L. SCHAFFER, B.A.

SPECIAL PROBLEM AREAS

PERSONNEL AND RESEARCH NEEDS

IMPLEMENTING IMPROVEMENTS

APPENDICES

Disabled.
One of the most damaging and inaccurate words in the English language.

Tell a man with a physical or mental handicap he's disabled. Tell him often. And your chances of crippling his spirit are excellent.

Disabled is a word that has "hopelessness" written all over it.

A word that suggests total impairment. Yet most often, it's one area that isn't functioning normally. One non-functioning area in a total human being and bingo!

Disabled.

If we could take the word out of the dictionary, we would. Since we can't, we'll do the next best thing. Change the meaning.

From now on, a "disabled" person is someone who can overcome his problem with medical aid. Someone who can learn to take care of himself. Someone who can be taught to do a job he likes.

If it sounds like we're talking about you (or someone you know and care for), write and tell us.

You've got nothing to lose but your disability.

Write: Help, Box 1200, Washington, D.C. 20013

PRINCIPAL RECOMMENDATIONS

More than 200 recommendations have been proposed to work towards a solution of the problems facing handicapped persons in Massachusetts. All require implementation. However, certain recommendations comprise an essential core around which other recommendations revolve. The Planning Commission designates the following 19 principal recommendations as having the highest priority, but emphasizes that their order does not intend to give any one of them more weight than any other.

Comprehensive Programs at the Community Level

GEOGRAPHIC SERVICE AREAS AND REGIONS

1. Comprehensive rehabilitation programs should be developed in each of the 37 geographic service areas subsumed within seven administrative regions to insure the availability of services to handicapped persons in all parts of the Commonwealth.

PRIORITIES AMONG AREAS

2. Geographic service areas should be ranked annually according to their relative need for rehabilitation services. Allocation of public resources should be guided by annual rankings. New Bedford, Roslindale, Government Center, Roxbury — North Dorchester, Cambridge — Somerville, Springfield and Worcester are currently ranked as high priority areas.

State Level Reorganization

REORGANIZATION OF THE MASSACHUSETTS REHABILITATION COMMISSION

3. The Massachusetts Rehabilitation Commission should be reorganized into four major sections, each headed by an Assistant Commissioner: Client Services; Community Programs; Planning, Training, Research and Education; and Administration.

STATE ADVISORY BOARD

4. A state Rehabilitation Advisory Board should be appointed by the Governor to advise the Massachusetts Rehabilitation Commissioner on policy and program development, to hold public hearings throughout the Commonwealth, and to review annual plans and the annual budget of the Commission.

REORGANIZATION OF THE MASSACHUSETTS COMMISSION FOR THE BLIND

5. The Massachusetts Commission for the Blind should be reorganized into four major sections, each headed by an Assistant Commissioner. Health, Social and Individual Services; Rehabilitation Services; Planning, Training and Research; and Administrative Services.

SETTING OF STANDARDS AND RATES

6. Legislation should be enacted establishing a Rehabilitation Facilities Board to set standards and rates for the purchase of nonmedical rehabilitation services by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind and to designate the proposed area disability evaluation centers, area sheltered workshops and area work evaluation and adjustment centers.

Components of Area Programs

SERVICES FOR ALL THE HANDICAPPED

7. An office of the Massachusetts Rehabilitation Commission, under the direction of an area rehabilitation director, should be established in each of the 37 geographic service areas to coordinate local rehabilitation services and assume responsibility for casefinding, evaluation, training, placement and followup of all handicapped persons.

AREA ADVISORY BOARDS

8. Area Rehabilitation Advisory Boards should be established within each geographic service area to advise the area rehabilitation director regarding local needs and resources, to review specific plans toward the development of comprehensive area programs, and to allow all interested citizens to participate in decisions at the community level.

DEVELOPING COMPREHENSIVE PROGRAMS

9. The use of contractual and fee for service arrangements and cooperative interagency agreements should be expanded by area rehabilitation directors to insure the optimum use of existing and planned public and private agency resources to stimulate the development of comprehensive area rehabilitation programs.

EARLY CASEFINDING

10. Schools, hospitals, courts, physicians and clergymen in each area should serve as alerting stations capable of early casefinding, recognizing potential vocational handicaps and of referring handicapped persons for evaluation and appropriate services.

Liaison consultants from the Massachusetts Rehabilitation Commission should foster the development of these alerting stations.

EVALUATION AND TREATMENT

11. Hospitals, workshops and other qualified agencies should be designated by the Rehabilitation Facilities Board as disability evaluation centers. These centers should provide preliminary and comprehensive evaluation, treatment and prevocational services on an inpatient and outpatient basis.

TRAINING AND SHELTERED EMPLOYMENT

12. At least one sheltered workshop should be designated in each geographic service area by the Rehabilitation Facilities Board as the major resource for transitional and extended workshop services and day activity services.

PLACEMENT AND FOLLOWUP

13. A suitable vocational placement should be provided to all handicapped persons after they receive appropriate vocational services.

A new cooperative agreement should be drawn between the Division of Employment Security, the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to facilitate the successful employment of handicapped persons.

Special Problem Areas

REMOVAL OF ARCHITECTURAL BARRIERS

14. To further enhance the prevention and removal of architectural barriers, legislation should be enacted to extend the jurisdiction of the architectural barriers board to cover all buildings generally open to the public such as office buildings, educational institutions, shopping centers, recreational and cultural facilities, mass transportation facilities, and places of worship.

ADJUSTING TO TECHNOLOGICAL CHANGE

15. A manpower policy and development unit should be established within the Executive Office of Administration and Finance to coordinate the planning of all manpower programs in the Commonwealth and to develop new policies and programs to offset the increasing inroads of automation and other technological and social changes.

SERVICES FOR THE PUBLIC OFFENDER

16. The Massachusetts Rehabilitation Commission, the Division of Employment Security, the Department of Correction, the Commissioner of Probation, the Parole Board, the Division of Youth Service and the county Houses of Correction should expand comprehensive evaluations, restorative services, vocational training and prerelease and post release programs for public offenders within the courts, correctional institutions and the community.

Personnel and Research Needs

SECURING ESSENTIAL PERSONNEL

17. In keeping with greatly expanding responsibilities and with anticipated increases in federal allocations, professional and clerical personnel at the Massachusetts Rehabilitation Commission should be increased from approximately 400 to 1,600 by 1976 and personnel at the Massachusetts Commission for the Blind should be increased from about 200 to 300 persons.

TRAINING PUBLIC AGENCY PERSONNEL

18. At least 10% of the annual personnel budgets of public agencies rendering rehabilitation services should be allocated for inservice training, educational leaves and student scholarships.

The Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Departments of Mental Health, Public Health, Public Welfare, Education, and Correction, the Division of Youth Service, the Division of Employment Security, the Commissioner of Probation and the Parole Board should include this amount in their annual budget requests.

Interagency training programs should be conducted whenever feasible.

EXPANDING REHABILITATION RESEARCH

19. Research units at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should be strengthened to enable them to undertake evaluations of rehabilitation programs and to assume leadership in stimulating rehabilitation research at universities and other private and public agencies.

CAPSULE REPORT

OUR HANDICAPPED CITIZENS

Too often, handicapped persons do not significantly participate in the life of their community — even though they may possess useful skills, or the capacity to learn these skills. It is a waste of human resources and a personal hell for a handicapped person to be an irrelevant bystander in our fast moving, work oriented society.

Who are the handicapped? Almost everyone is aware of the physically disabled person in a wheelchair or on crutches, the mentally ill or retarded person, the blind person using a cane or seeing eye dog and, to a lesser extent, some awareness exists about problems of the deaf person. Yet, there are additional handicaps which are more prevalent but not as obvious to the public eye, such as the chronically unemployed, the poor, the public offender, the aged, and the socially disadvantaged.

To illustrate, a handicap may result when:

- A person suffers from a chronic or progressive physical or mental illness.
- A person is too old, too poor, or lacks the education to hold a steady job.
- A public offender is released from prison without a job skill.
- A craftsman is replaced by an automated machine.
- A person is injured by accident at home, at work, or while traveling.

The Planning Commission defines a handicapped person as someone with one or a combination of physical, mental, educational, age, income, environmental or skill disqualifications. These disqualifications or handicaps act to impair an individual's ability to perform his major life activity.

Traditionally, vocational rehabilitation services have been provided only for those persons who could ultimately engage in competitive employment. Services should be extended to enable all handicapped persons to perform their major life function whether this be competitive employment, attending school, housework or sheltered employment.

Just as influences outside an individual's control frequently induce handicaps, environmental factors may reinforce the handicap and impede rehabilitation. A person might find it difficult to overcome his disqualification from major life activities because of negative attitudes against rehabilitating an ex-convict or an ex-mental patient or because health and welfare services favor one economic or ethnic group over another.

Ultimately, the goal of all rehabilitation activities should be to enable handicapped persons to perform their major life activities and to return them to the mainstream of normal daily living. The accomplishment of this goal will improve the self esteem of handicapped persons, enable them to become economically self sufficient and increase their contribution to society.

SCOPE OF PROBLEM

Almost 400,000 people of all ages in Massachusetts are substantially restricted by physical or mental disabilities from carrying out the major life activities expected to be performed at various stages of life.

- More than 350,000 of these people live at home.
- About 45,000 persons are patients or residents in public institutions for the physically disabled, mentally ill, mentally retarded or are inmates in state correctional institutions.

When we add the thousands of persons who are not physically or mentally disabled but who are aged, uneducated, replaced by automation or living at or below marginal subsistence levels, the rehabilitation problem reaches staggering proportions.

In fiscal 1968, the Massachusetts Rehabilitation Commission and the vocational rehabilitation program of the Massachusetts Commission for the Blind...

...rendered services to 11,997 persons.

...rehabilitated 3,325 persons according to federal administrative criteria.

When we consider that there are 400,000 physically and mentally disabled individuals in the Commonwealth plus an undetermined number of persons handicapped by age or social or environmental factors — the task of expanding rehabilitation programs becomes formidable.

GUIDEPOSTS FOR DELIVERING SERVICES

Legislators, administrators, professionals, concerned citizens and consumers of services are becoming increasingly aware of the complexities involved in the delivery of quality health, welfare and rehabilitation services. Clients have difficulty in negotiating the labyrinth of agencies providing a variety of specialized services. Specialists are becoming further specialized. Frequently, the personal touch is lacking. Gaps and overlapping appear to occur simultaneously. Even though more money is expended, the results do not meet expectations. Citizens seeking services are sometimes confronted with incomprehensible regulations, eligibility criteria, long waiting lists, and other obstacles. To receive help, individuals are expected to develop expertise in negotiating a maze of agencies, officials and forms.

These and similar observations, were reinforced at public hearings held by the Vocational Rehabilitation Planning Commission in Boston, Lowell, New Bedford, Pittsfield, Springfield and Worcester.

At the present time, the Governor and the state legislator are seeking ways to reorganize health, welfare and rehabilitation services (human services) to provide a more effective framework for delivering comprehensive programs throughout the Commonwealth. In anticipation of these overall

human service plans, the Vocational Rehabilitation Planning Commission utilized certain guideposts which are applicable to all public and voluntary human service efforts. These guideposts include:

- Locally available and accessible services with decentralization of administration and program development.
- Improved coordination among all human service programs at local points of service delivery.
- Careful determination of program components before facilities are planned or built.
- Workable partnerships between governmental and private agencies.

Uniform geographic service areas should be used by all human service agencies throughout the state. Services must be developed to provide a comprehensive array of human service programs on behalf of the consumer in his community and even in his neighborhood, if necessary.

When persons in need are either not being served or are not being served adequately, critics of the system call for coordination. What is usually meant is coordination among agencies or service units. Frequently, the client for whom the coordination is intended is overlooked. Effective coordination results in all clients receiving all the services they need. To achieve this degree of coordination requires proper referral coupled with effective followup.

An important guidepost to the provision of services is the careful determination of program requisites before facilities are planned or built. Bricks and mortar constitute expensive portions of any service system. In the past, some institutions in the Commonwealth were constructed without careful consideration of the kinds of services and clients best suited to a particular physical setting.

With respect to public programs, building costs are now at the point where essential programs may have to be curtailed unless agencies can find ways to share facilities and integrate programs on behalf of clients requiring assistance from a variety of auspices. Wherever possible, existing agencies and existing facilities should be utilized. Duplicate service systems should be avoided.

Workable partnerships between governmental and private organizations will be required, if the Commonwealth is to meet future challenges and demands upon our human resources. Governmental programs must be opened to the scrutiny of concerned citizens and consumers of services and should accept their advice on policy and programs. Increasingly, voluntary agencies will need to adhere to public standards of service and public certification of their activities. Voluntary agencies must review their policies and decide whether their agencies can augment governmental programs and accept public funds to expand their services. Give and take on both sides will be necessary to achieve the goal of comprehensive services to all.

These essential guideposts for the delivery of human services underlie the proposals of the Massachusetts Vocational Rehabilitation Planning Commission.

THE FEDERAL-STATE VOCATIONAL REHABILITATION PROGRAM

When first established, the public vocational rehabilitation program in the United States set out to vocationally rehabilitate physically disabled persons. The federal government provided funds on a matching basis, set standards, and the states provided services to clients. Over the years, the federal-state program was broadened to include mentally disabled and more recently, behaviorally disordered persons. In 1968, socially disadvantaged persons were included within the program. Initially, the program included only those adjudged capable of remunerative employment. Recently, rehabilitation services were expanded to include individuals for whom there is a reasonable chance that they may accomplish any useful work — competitive or not. In effect, the federal-state program broadened its public mandate to include those unable or presently disqualified from performing a major life task — a job, homemaking, or sheltered work.

Considerable attention has been focused upon the unique strengths of the public rehabilitation program in providing services to handicapped persons, including:

- Developing an individualized plan for each client requiring rehabilitation services.
- Keeping the objective of the employability or independent life functioning of each handicapped client foremost.
- Maintaining fiscal flexibility in the provision of client services allowing required services to be purchased from public and private resources best able to contribute towards a client's rehabilitation goal.

These strengths stand out in contrast to the fragmented organization of most other health, social service and manpower programs. Generally, health and social service programs only utilize services available within the particular agency when working with clients. If additional services are needed outside of an agency's service mandate, the additional services are frequently viewed as ancillary or supplementary to the services provided by the host agency.

In the past few years, federally supported manpower programs have grouped disadvantaged, unskilled or underskilled persons into a variety of vocational training and work adjustment programs. At times, the individual vocational needs of persons become subordinate to the pressure to fill enrollment quotas. Furthermore, necessary supportive social and health services to assist clients in adjusting to the work world are frequently lacking.

In contrast, the vocational rehabilitation program has the potential to bring to bear a coordinated array of resources to help disabled and disadvantaged persons achieve dignified stations in life. With all of the constructive implications for the family and for the community, the vocational rehabilita-

tion model can be a promising tool for serving the total needs of handicapped persons. Responsiveness to special needs of individual clients may considerably enhance rehabilitation goals.

Today, Massachusetts has an unprecedented challenge to meet the national mandate of the federal-state vocational rehabilitation program to extend services to previously unserved groups. The opportunity exists to expand and to improve the Massachusetts public vocational rehabilitation program. A plan of action to provide for the orderly development of needed services through fiscal 1976 is the challenge.

FUNDS AVAILABLE TO THE STATE

As the federal-state vocational rehabilitation program expanded, the share of federal funds to Massachusetts also increased:

- In fiscal 1965, authorized federal funds totaled $2,851,109.
- In fiscal 1967, authorized federal funds totaled $6,328,456.
- In fiscal 1971, federal funds will rise to about $18 million.
- By fiscal 1976, estimated federal funds may be more than $40 million.

To date, the Commonwealth has not allocated the funds required to earn the maximum federal grants available to the state. Beginning in fiscal 1970, one dollar of state or private funds will be matched by four dollars provided by the federal government, for the general vocational rehabilitation program. For some special programs, one state dollar will be matched by nine dollars from the federal government.

The budget for vocational rehabilitation services in the Commonwealth could easily grow to more than $55 million in the next eight years, if all state and local matching funds are appropriated.

STATE LEVEL REORGANIZATION

To move rapidly towards the accomplishment of the challenging vocational rehabilitation task, strong, highly qualified and adequately compensated leadership will be required in the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind. Serious manpower shortages and difficulties in retaining top calibre staff must be overcome by sustaining professional working standards and salaries competitive with similar positions in other states.

MASSACHUSETTS REHABILITATION COMMISSION

Created in 1956, superceding the former Division of Vocational Rehabilitation of the Department of Education, the Massachusetts Rehabilitation Commission is responsible for the vocational rehabilitation of handicapped persons. The single exception to this authorization is that legally blind persons are served by the Massachusetts Commission for the Blind.

The Massachusetts Rehabilitation Commission should be the state level coordinating agency for the rehabilitation of all handicapped persons in the Commonwealth. Efforts should concentrate upon the provision of client services and the orderly development of comprehensive and accessible public and private rehabilitation programs throughout the Commonwealth. Major administrative and program instruments of the Massachusetts Rehabilitation Commission should include contracts, cooperative agreements and fee for service arrangements which will extend services and reduce the need for capital outlays for new facilities.

Reorganization of the Massachusetts Rehabilitation Commission should include:

- Geographic decentralization of rehabilitation programs into service areas and administrative regions.
- Appointment of Area Rehabilitation Advisory Boards throughout the state to assure effective citizen participation in local rehabilitation programs.
- Reorganization of the central office of the Massachusetts Rehabilitation Commission into four major sections, each headed by an Assistant Commissioner: Client Services; Community Programs; Planning, Training, Research and Education; and Administration.
- Creation of the position of Deputy Commissioner.
- Appointment of a state Rehabilitation Advisory Board composed of citizen members, including consumers of rehabilitation services.
- Creation of a state Rehabilitation Coordinating Council to promote effective interagency communication and active cooperation in the planning and provision of rehabilitation services.
- Establishment of a Rehabilitation Facilities Board to set standards and rates for nonmedical rehabilitation services provided by facilities and to designate the proposed area disability evaluation centers, area sheltered workshops and area work evaluation and adjustment centers.

MASSACHUSETTS COMMISSION FOR THE BLIND

In 1966, with the establishment of the Massachusetts Commission for the Blind, the legislature underscored its intent to maintain a single agency to provide comprehensive

social and rehabilitation services and financial assistance to blind persons of all ages and stations in life.

Future plans for the consolidation of public programs for human services, including those for blind persons, should call for a strong integrated rehabilitation, social service and income maintenance program for all disabled and disadvantaged individuals.

At this time, the Planning Commission recommends retaining a separate agency for the blind which closely coordinates its activities with the Massachusetts Rehabilitation Commission and other human service programs. This recommendation is based on the fact that in addition to rehabilitation programs, the Massachusetts Commission for the Blind provides general social services, income maintenance and medical assistance (Medicaid). A variety of specialized programs such as home teaching, children's services and talking books are also provided by the Massachusetts Commission for the Blind.

Although the activities and programs of the Massachusetts Commission for the Blind are well accepted, public support is needed to achieve an upgrading of administrative and professional positions and to provide salaries commensurate with responsibilities. The following changes are recommended:

- Reorganization of the Massachusetts Commission for the Blind into four major divisions, each headed by an Assistant Commissioner: Social and Individual Services; Rehabilitation Services; Planning, Training and Research; and Administrative Services.
- Strong coordinating ties to the Massachusetts Rehabilitation Commission.
- Establishment of a position of Deputy Commissioner.

DECENTRALIZATION OF REHABILITATION SERVICES

The Commonwealth should be divided into geographic service areas to decentralize administration and program development within the Massachusetts Rehabilitation Commission and other public agencies serving disabled and disadvantaged persons. These geographic service areas (currently 37), ranging in population between 75,000 and 200,000 people, will be able to evaluate needs and resources at the point of delivery, facilitate casefinding, coordination and service continuity and stimulate citizen participation. Service areas should be kept sufficiently small so that no person travels more than one hour to obtain needed services.

Utilization of uniform geographic service areas and regions has already been adopted by the Department of Mental Health and Public Welfare. In 1968, the Commissioner of Administration extended this policy to other departments and agencies.

Seven rehabilitation administrative regions should be formed, each comprised of five to seven contiguous service areas. Regional programs will be able to develop specialized services within the areas, supervise consultants and other expert persons to analyze and evaluate the programs in their areas, and consolidate area program and budgetry needs for transmittal to the state central office.

AREA REHABILITATION PROGRAMS

The Massachusetts Rehabilitation Commission should establish an office in every geographic service area, headed by an area rehabilitation director, to provide rehabilitation services for disabled and disadvantaged persons within their areas and to develop comprehensive area rehabilitation programs.

A comprehensive area rehabilitation program should include the following minimum services:

- Prevention, casefinding and outreach
- Comprehensive vocational evaluation
- Physical and mental restoration
- Personal adjustment training (prevocational)
- Vocational training
- Vocational-technical education
- Undergraduate and professional education
- Transitional and extended sheltered employment
- Vocational placement and followup
- Day care for adults
- Personal counseling
- Social and recreational programs
- Special housing
- Transportation
- Homebound employment
- Homemaking, attendant and other services in the home
- Consultation to agencies

Development of comprehensive rehabilitation services will not necessitate the establishment of a multiservice center in each area to provide all of the needed rehabilitation services. Public and private agencies meeting required standards and presently providing any of the required rehabilitation services might expand to provide services not now available. Only when existing agencies cannot provide some of the necessary services should the Commonwealth establish new programs to provide these services directly.

Whenever possible, services should be provided as close as possible to the client's home. The center fold chart shows how disabled and disadvantaged persons living in a geographic service areas are found, registered, evaluated, provided with needed services and placed.

Availability of rehabilitation services close to where potential clients live is the underlying principle for dividing the Commonwealth into geographic service areas. Economic resources, population density and the present availability of services differ drastically from one area to the next, particularly in rural and urban areas. Priorities for expanding services or for providing new programs should be based on the need for rehabilitation services within the geographic service area coupled with existing and potential available resources in that area.

Area rehabilitation directors of the Massachusetts Reha-

bilitation Commission, in consultation with the area rehabilitation boards, should assume the responsibility for coordinating rehabilitation services in each area. This responsibility does not imply administrative or policy making control over participating agencies. Rather, coordination takes place when the area rehabilitation director arranges for public and private agencies to commit themselves to provide needed services on their own or enters into contracts with these agencies to purchase services.

Coordination is needed on the area level to limit duplication of services, to insure that the full range of services are provided, to maintain high standards, and to insure accessibility of services. One of the major responsibilities of the area staff of the Massachusetts Rehabilitation Commission is to help local agencies and practitioners understand the cooperative role each of them plays in building a comprehensive rehabilitation program.

AREA STAFF AS CLIENT ADVOCATES

The area staff of the Massachusetts Rehabilitation Commission and assigned staff from the Massachusetts Commission for the Blind, should actively pursue the role of client advocates. Local staff persons should view themselves as the advocate of all handicapped persons residing in the area. In many instances, the rehabilitation counselors have performed this role for persons eligible for the public program. In the future, this advocacy role should be performed for all handicapped persons, whether or not they are eligible for services funded by the federal rehabilitation program. Area rehabilitation programs should provide pathways for the meshing of appropriate services to the handicapped persons regardless of the source of funding for such services. Coordinating services for the handicapped will be carried out in name only unless advocacy responsibilities are seriously undertaken.

ALERTING STATIONS

Preventing the onset and minimizing the vocational handicaps should receive a high priority in an area rehabilitation program. Clergymen and physicians, schools, hospitals, mental health-retardation centers, schools for the retarded and correctional institutions, local health departments, local welfare offices, visiting nurse associations and other social service agencies can all serve as potential alerting stations. Practitioners and agency personnel should alert the area office of the Massachusetts Rehabilitation Commission and other appropriate rehabilitation agencies to persons with potential vocational handicaps.

To detect the greatest number of potential cases, a new position of liaison consultant should be established by the Massachusetts Rehabilitation Commission. Liaison consultants should work with staff members of alerting stations which first come into contact with people with existing or potential handicaps. These liaison personnel should provide consultation, education, and assistance in expediting clients to all other necessary services.

VOCATIONAL EVALUATIONS

One of the serious bottlenecks in helping people through the rehabilitation process is the manner in which evaluations are made by state rehabilitation agencies. Sometimes a client has to wait for months before eligibility for the public rehabilitation program is determined and a rehabilitation plan developed. One reason for this delay is the fragmented method of collecting a variety of medical, psychological and vocational examinations and evaluations to give a complete assessment of a client's potential for rehabilitation. This bottleneck in the evaluation of a client's potential should be eliminated by instituting interdisciplinary team evaluations which could be completed in short periods of time, sometimes in a few hours, at agencies designated by the proposed Rehabilitation Facilities Board for this purpose.

- For those with primarily physical disabilities, area disability evaluation centers such as hospitals or rehabilitation centers should be designated.
- For those with primarily mental disabilities, area mental health-retardation centers should be designated.
- For those with primarily undifferentiated vocational or social handicaps, designated area sheltered workshops or other work evaluation and adjustment centers should be used.

AREA SHELTERED WORKSHOPS

Sheltered workshops comprise an important resource for vocational evaluation, training and placement. Work skills of clients can be evaluated over a period of time in a simulated job setting. Work demands can be adjusted to the client's specific ability.

Approximately 5,500 disabled persons received services at sheltered workshops in Massachusetts during 1966-67. However, only 150 persons attended workshops located outside of major cities. Workshop services are needed in all parts of Massachusetts.

At least one sheltered workshop in each geographic service area providing transitional and extended workshop services and day activity programs should be designated as a major resource for rehabilitation services by the proposed Rehabilitation Facilities Board. These sheltered workshops should provide evaluation, personal adjustment and work training programs and placement and followup to a mixed clientele of vocationally handicapped persons including the physically and emotionally disabled, retarded, and others who may have vocational handicaps and who could benefit from a sheltered work training experience.

Workshops should play an important role as a community placement for residents from mental hospitals, schools for the retarded, prisons and other institutions. Used in conjunction with halfway houses and other supportive services, workshops can provide residents with an important link between the institution and the community.

DAY ACTIVITY PROGRAMS

To meet the requirements of more severely disabled persons who may not be capable of work, designated area sheltered workshops and other appropriate agencies should institute day activity programs. Such programs should stress self care skills, recreation and social interaction. The Massachusetts Rehabilitation Commission and the Department of Mental Health, Public Health, Public Welfare, Education and Correction should explore the possibilities for joint financing of extended employment and day activity services.

HOMEBOUND EMPLOYMENT

Handicapped persons who cannot leave their home on any regular basis, but who are capable of performing some work, should be provided with homebound employment.

Homebound employment should be a part of the responsibility of each designated area sheltered workshop. Subcontracts with industry and other employers should be channeled through the area sheltered workshops with suitable types of work designated for the homebound.

The Industrial Home Work Law places a number of significant restrictions on work produced in the home. Sections of this law should be changed to permit the increased homebound employment.

In addition to work, homebound persons often need other forms of help such as medical services, counseling and help with shopping. Each area office of the Massachusetts Rehabilitation Commission should assume responsibility for providing supportive services for homebound persons in the area, directly or by referral. There is no precedent for providing homebound services of this type and newly developing models should be carefully evaluated.

TRANSPORTATION

Transportation for education and treatment should be a basic responsibility of the Commonwealth. Transportation subsidies to permit disabled persons to work and to participate in social and religious activities should receive careful consideration. Agencies serving disabled persons should assume responsibility for transporting clients who require such help to utilize the services.

Administrative details for clients' transportation can best be worked out by individual agencies with either their own vehicles or by contracts for services. Agencies should receive transportation planning and financial help from the area office of the Massachusetts Rehabilitation Commission.

HOUSING

Housing needed by physically disabled persons to maintain themselves independently varies greatly from one individual to the next. Some persons may only need a ramp or doorway wide enough to maneuver their wheelchair. Others with more serious physical handicaps may require certain supportive services such as help with dressing, marketing, transportation and certain domestic chores. Some may also need minor nursing services.

Because suitable housing is such an important problem for so many disabled persons, a major effort should be made in each geographic service area to insure adequate housing. At the present time, occupancy in public housing by a single handicapped person is prohibited by Massachusetts law. Eliminating this restrictive provision would make low cost housing available to many in need of adequate housing.

A housing coordinator should be on the staff of each area office of the Massachusetts Rehabilitation Commission to organize and develop programs for stimulating the expansion of housing resources for disabled persons. A housing advisory committee composed of local citizens, including handicapped persons, should be established by each area rehabilitation board to assist the housing coordinator.

VOCATIONAL PLACEMENT AND FOLLOWUP

In the past, undue focus centered upon the limitations of a handicapped person. Current trends suggest concentrating upon the fullest use of the individual's untapped and undeveloped capabilities. Placement in employment should not be influenced by charity or pity, but should be determined by the specific abilities of the disabled individual just as with the nondisabled person.

Disabled people encounter many problems in attempting to locate employment. Persons in wheelchairs, on braces or crutches, and occasionally blind persons, experience transportation difficulties and general problems with mobility. Others, such as the alcoholic, are faced with negative attitudes. Mentally retarded individuals are often immature and unprepared to accomplish a vocational role and other common adult tasks. Many rehabilitated individuals require continuous supportive care, such as the epileptic person needing medication to prevent seizures, the mentally ill person involved in psychotherapy or the paraplegic requiring prosthetic maintenance.

To enhance vocational placement and followup services, a new cooperative agreement should be drawn between the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security, which clearly delineates their respective procedures for evaluating, preparing, placing and following up clients. This agreement should be based upon the recommendations and findings of the Planning Commission which deal with procedures for referral, availability of job listings, consultation to private agencies serving the disabled and services to persons returning to the community from institutions and hospitals.

Revised followup procedures of the Massachusetts Rehabilitation Commission should include an initial intensive 90 day followup to assist the client in adjusting to the demands and requirements of the job. At the end of this time period, a general followup plan should be organized for at least an additional nine months.

Because of the specialized knowledge required to properly assist handicapped persons and employers, rehabilita-

tion personnel should receive training in job placement methods and techniques as well as followup procedures. A new role for the Massachusetts Rehabilitation Commission should be that of consultant to other agencies in the area of placement and followup.

To expand working agreements between industry and vocational rehabilitation agencies, the Massachusetts Commission on Employment of the Handicapped should be given additional funds and staff to augment and expand its program of promoting jobs in local areas throughout the Commonwealth.

ARCHITECTURAL BARRIERS

In every community in Massachusetts, the large majority of buildings and facilities commonly used by the public have architectural features which bar the handicapped. Most people are unaware of this problem although one out of every ten Americans is affected. In Massachusetts, a mandate for the prevention of architectural barriers now exists. Recent legislation established a state board for architectural barriers located in the Department of Public Safety. This board is empowered to establish standards for the prevention or removal of architectural barriers in buildings financed with public monies. This is a significant first step.

A further step should be the enactment of legislation to extend the jurisdiction of the architectural barriers board to include all buildings generally open to public use regardless of the source of funding. A large number of buildings used by the public, but financed from private or federal resources, are vital to the everyday activities of disabled persons. These include buildings used for education, training, employment, shopping, recreation, worship, and medical care.

PUBLIC OFFENDERS

Some confusion exists concerning the goals of crime prevention and the rehabilitation of the public offender. Rehabilitation programs have been opposed on the grounds that they undercut the deterrent effect of criminal penalties and hamper efforts to prevent crime. However, there is no real conflict between crime prevention and rehabilitation since the rehabilitation of offenders is, in general, the most promising way to reduce crimes.

Except for periodic responses to crisis situations within the correctional system, the development and expansion of rehabilitation programs has not received sufficient public support. Increased emphasis on correctional rehabilitation, both in the community and in institutions, must accompany the development of vocational rehabilitation services for offenders.

No state governmental function is more fragmented than the post conviction phase of criminal justice. Responsibility for control and rehabilitation of convicted offenders is divided among six state agencies, 14 counties and the city of Boston.

Vocational rehabilitation for public offenders on parole or probation is almost totally lacking. Only a handful of offenders received any vocational rehabilitation services from the Massachusetts Rehabilitation Commission in 1967. A great majority of prisoners are uneducated, unskilled, and disabled. Medical histories of the inmates disclose many cases of mental illness, retardation and personality disorders as well as physical disability.

Juvenile offenders on parole or probation urgently need vocational rehabilitation services, especially counseling, prevocational and training services. Reports of probation officers and others who work with the juvenile offender indicate that many of the juveniles lack educational achievement, are unmotivated and unrealistic about vocational goals.

All public offenders should receive a comprehensive medical, psychological, social and vocational diagnosis and evaluation as early as possible before permanent assignment to an institution. Specific programs should include increased attention to the medical needs of offenders, the overhaul of prison industries, eliminating obsolete work conditions, expansion of work release programs, augmenting prerelease and postrelease vocational programs and the provision of more diagnostic and evaluative vocational services.

The Massachusetts Rehabilitation Commission has already expanded its program for the public offender by appointing a director of services to the public offender and by establishing five significant innovative projects with state and county correctional agencies.

TECHNOLOGICAL CHANGE AND OCCUPATIONAL PATTERNS

Individuals and organizations concerned with providing rehabilitation services usually focus on the means necessary to rehabilitate individuals who are handicapped. Yet, considering technology's impact upon occupational patterns, a society is handicapped if it fails to make full social use of the talents, skills and potential of individuals in ways that contribute to the development of society through occupational roles that are personally meaningful to the individual.

To achieve a better integrated, more rational and more effective state policy and plan for expanding and improving job opportunities and manpower programs — both now and for future decades — there must be leadership and direction from the state executive office. A manpower policy and development unit should be established in the Office of Planning and Program Coordination, the Governor's instrument for comprehensive statewide planning, within the Executive Office of Administration and Finance.

Four major objectives of this proposed manpower planning unit should be:

- Coordination of manpower policy and plans.
- Development of improved means for matching people with jobs.
- Creation of new occupational roles to fit diverse needs and abilities.
- Continuing adaption of educational institutions and programs to technological and social change.

In addition to the manpower program and development

staff, the Governor should appoint a citizen's advisory committee to provide contact with manpower experts and outstanding citizens.

DEVELOPING PERSONNEL TO PROVIDE REHABILITATION SERVICES

Current manpower shortages show no promise of significant improvement. Physicians, occupational therapists, psychiatrists, psychologists, school teachers, rehabilitation nurses, rehabilitation counselors, social workers, guidance counselors, and speech and hearing therapists are all concerned with rehabilitation. All suffer manpower shortages. How can scarce and increasingly costly professional and technical manpower be effectively utilized to serve the greatest number of individuals with high quality programs? As rehabilitation programs continue to serve more people with chronic and complex problems, how can new workers be recruited and trained?

By fiscal 1976, professional and clerical personnel should be increased drastically to provide expanded and effective rehabilitation services throughout the Commonwealth and to reflect anticipated increases in federal allocations as follows:

- Personnel at the Massachusetts Rehabilitation Commission should increase fourfold — from about 400 to 1,600.
- Personnel at the Massachusetts Commission for the Blind should increase from about 200 to 300.

Inservice training, especially in our public agencies, can no longer be treated as a low priority item in personnel budgets. High quality professionals are recruited and retained by continued educational challenges and opportunities to sharpen their knowledge and competencies.

If Massachusetts is to compete with other states in recruiting and retaining high calibre service personnel, the Massachusetts Rehabilitation Commission, the Commission for the Blind, Departments of Mental Health, Public Health, Public Welfare, Education, Correction and the Division of Youth Service should spend at least 10% of their annual personnel budgets for inservice training, educational incentives and sudent scholarships. Interagency training programs in rehabilitation should be developed by the state Rehabilitation Coordination Council.

Efforts to retain and attract qualified rehabilitation personnel should begin with the establishment of minimum educational requirements and sharply increased salaries. A three level entry and pay grade classification structure for rehabilitation counselors and social workers should be instituted at the Massachusetts Rehabilitation Commission and the Commission for the Blind. A four level position and pay grade structure should be established for supervisors and administrators in these agencies. Levels should reflect differences in experience, education, background and responsibilities and should be competitive with other state and private rehabilitation agencies.

The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should offer appropriate entrance salaries and increments based on educational background, experience and present responsibilities, to encourage experienced professional staff to remain with the agencies. Furthermore, these steps will foster recruitment of qualified candidates nationwide and allow for advancement within the agency.

Special positions of rehabilitation trainees outside of civil service should be established for persons who may lack educational requirements, but who may be suited to aid counselors and administrators in their work.

The Planning Commission adds its voice to the conclusions of many expert and citizen groups urging that Massachusetts revise its present system of absolute preference for veterans to follow the federal pattern of bonus points for veterans. This revision is vital to attract quality personnel for public service.

EXPANDING REHABILITATION RESEARCH IN MASSACHUSETTS

With its many excellent academic facilities and health, rehabilitation and social agencies, Massachusetts has a unique opportunity to expand rehabilitation research efforts.

Emphasis should be placed upon sensitizing researchers to basic concepts of disability and helping them to develop an early interest in the rehabilitation field. Undergraduate, graduate and postgraduate programs should be supported by the federal Rehabilitation Services Administration. Since day to day operational research depends so heavily upon technical personnel responsible for data computation and routine procedural duties, a program for training technical research specialists should be added to the curricula of community and junior colleges. This new program as well as continuing education in research for rehabilitation practitioners, should be encouraged and assisted by the Massachusetts Rehabilitation Commission.

Researchers and practitioners sometimes speak different languages and are not concerned with each other's problems. In addition, lack of communication between researchers and practitioners often result in research findings not being implemented. Communications should be strengthened by collaborative efforts including:

- Interuniversity conferences promoting continuing exchanges among those involved in rehabilitation research and practice.
- Establishing a journal devoted exclusively to rehabilitation research (no such journal now exists).
- Consultation by the Rehabilitation Research Institute of Northeastern University to agencies conducting rehabilitation research.

Demands will continue to mount upon the research programs of the Massachusetts Rehabilitation Commission including requests for processing and evaluating grants, consulting with outside agencies, and directing operational and evaluative research. To meet its responsibility for rehabilitation research, the Massachusetts Commission should upgrade its present research unit by creating a permanent position of research director. Adequate staffing should be provided for carrying out research responsibilities.

A coordinated program of rehabilitation research should be established between the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind. The state agency for the blind should have the services of a full time researcher assigned to vocational rehabilitation research.

A joint research advisory committee should be established by the state vocational rehabilitation agencies.

FINANCING REHABILITATION SERVICES

In recent years, the Commonwealth has expanded its services to handicapped persons and rehabilitated increased numbers of disabled persons each year. The federal Vocational Rehabilitation Amendments of 1965 and 1968 contributed to this broadened scope of rehabilitation programs at the state level, and increased the funds for this federal-state partnership significantly. Legislative support for the rehabilitation programs may be attributed to the proven value of the vocational rehabilitation program in terms of costs and benefits.

Income generated by rehabilitation services can be measured in savings to taxpayers. In 1967, Massachusetts spent $1,142,686 in state funds for rehabilitation services and produced these returns:

- 2,169 rehabilitated persons had a total yearly income at case closure of seven million dollars, a gain of nearly six million dollars over their income at acceptance to the program.
- Increased state sales and income taxes from these persons totaled more than $50,000.
- Reduced costs to the state for institutional care and public assistance to these individuals represented an annual savings of approximately $500,000.

These statistics reflect only the tangible return in one year of the state's rehabilitation investment. When the expected lifetime earnings of rehabilitated persons is considered, the benefits to be gained by the investment of public funds becomes truly significant. In addition, the intangible value of restoring an individual to his fullest capacity to perform a meaningful life activity cannot begin to be estimated.

In the near future, both the numbers of individuals in need of rehabilitation services, and funds available for rehabilitation programs will increase significantly. By fiscal year 1976, it is estimated that the Massachusetts share of the federal-state rehabilitation program will increase five-fold to approximately $40 million.

In addition, increased federal aid in other areas such as mental health and welfare will provide additional funds for rehabilitation services.

Within this context of increased federal funds to be matched by the Commonwealth, the following estimates of the cost of recommended programs may be made:

- The cost of implementing a minimum catch-up rehabilitation program in fiscal year 1971 will be approximately $32 million. Of this amount, $12 million, about 38%, will have to be made available from state funds.
- By fiscal 1976, the total program recommended by the Planning Commission will cost approximately $66 million annually (at 1968 prices). Of this amount, $20 million, about 30% will have to be made available from state funds.

This investment may be expected to produce a return to the Commonwealth of tangible benefits in decreased public assistance and increased tax receipts. The intangible element of the value of a meaningful life to handicapped persons may not be computed statistically, but must be considered as part of the return on the investment.

FIRST STEPS TO IMPLEMENTATION

Implementing the Planning Commission's major proposals will require the concerted activity of many groups and individuals. Some actions are underway. Others must be started to assure a continuing structure for implementation.

The Executive Committee for the Planning Commission will continue in an advisory capacity to the Executive Office of Administration and Finance. The Director of the State Office of Planning and Program Coordination will serve as a staff secretary to the Executive Committee and act as the Governor's liaison in the implementation stage of the Planning Commission's work. With the cooperation of the Massachusetts Rehabilitation Commission, plans are underway to assure that adequate staffing is secured for drafting statutory changes, liaison with the legislature, and other essential implementation procedures.

These arrangements will allow the closest possible coordination between the Planning Commission's program goals and those of the Office of Planning and Program Coordination. Rehabilitation services will be a major component in any plans to reorganize the state's human service programs presently being developed within the Governor's executive planning agency.

Increasingly, the complex task of planning for future programs requires each public agency to develop an effective planning capability. In Massachusetts, the Commissioner of Rehabilitation and the Commissioner for the Blind are already preparing for permanent planning units. Planning units in the vocational rehabilitation agencies will speed the implementation of many Planning Commission recommendations.

To a large extent, implementation will also require the united efforts of Planning Commission members, persons who were involved in task forces and public hearings, self help groups, and recipients and potential recipients of rehabilitation services throughout the state.

Proposals of the Planning Commission cannot be realized without the help of these same citizens. Active support is needed for legislative, administrative and program recommendations. In the long run, citizen participation on state and area rehabilitation boards will greatly contribute to sustain the momentum for improved and expanded rehabilitation services for all handicapped persons in the Commonwealth.

Our ultimate goal should be the return of our handicapped fellow citizens into the mainstream of activity and productivity. To do otherwise would be to disavow our humane traditions.

REHABILITATION CHARACTERISTICS OF GEOGRAPHIC SERVICE AREAS

RECOMMENDATIONS

DIVISION INTO AREAS

1. The Commonwealth should be divided into 37 geographic service areas to insure the accessibility of comprehensive rehabilitation services to all disabled and disadvantaged persons.

IDENTICAL SERVICE AREAS

2. Rehabilitation service areas should be identical to the existing mental health-retardation and public welfare service areas in order to facilitate the coordination and future integration of service at the point of delivery.

AREAS WITHIN REGIONS

3. The Commonwealth should be divided into administrative rehabilitation regions comprised of contiguous service areas for coordination, supervision, and direction of activities within areas. Rehabilitation regions should be identical to existing mental health-retardation regions.

PRIORITIES AMONG AREAS

4. Priorities for expansion of rehabilitation programs and services should be based on a ranking of rehabilitation service areas according to their relative need-resource position.

A RATIONALE FOR GEOGRAPHIC SERVICE AREAS

Recent significant developments in comprehensive planning for Massachusetts influenced the Planning Commission's decision to recommend division of the Commonwealth into 37 geographic areas for the administration of rehabilitation services. The Massachusetts Mental Health Planning Project, 1963-65, developed the concept of geographic service areas within Massachusetts. Areas proposed were also used by the Massachusetts Mental Retardation Planning Project, 1964-66. Although some changes have been made in area boundaries since the publication of these reports, the concept of utilizing identical service areas, at present numbering 37, was adopted by the Departments of Mental Health and Public Welfare, and will be considered by the newly created Comprehensive (Public) Health Planning Project organized under P.L. 89-749.

Division of the state into areas provides a new model for the organization of rehabilitation services which will:

- Increase the availability and accessibility of services at the community level.
- Facilitate the coordination and future integration of public and private services at the point of delivery for all human service programs.
- Broaden boundaries of service systems from which data is collected so that area patterns of public, private and voluntary services may be determined.
- Allow the evaluation of needs and resources within and among areas in order to guarantee the same essential services in each area
- Establish a basis for increased citizen participation in the planning and implementation of rehabilitation services.

Two key goals of the Planning Commission which require decentralizing services into geographic service areas are:

- Comprehensive rehabilitation services should be available throughout the state.
- Contractual and fee for service arrangements should expand to insure the optimum use of scarce public and private resources.

Geographic service areas will serve as an important component in the decentralization of administrative functions within the Massachusetts Rehabilitation Commission and other state agencies serving disabled and disadvantaged persons. Service areas, which will range in population roughly between 75,000 and 200,000, will be the primary administrative unit for direct client services within the rehabilitation service system. The 37 geographic service areas are indicated on the maps at the end of this section.

REGIONALIZATION

Following the model of the mental health-retardation service system in Massachusetts, the Planning Commission also recommends the division of the Commonwealth into rehabilitation administrative regions. Regions would be formed of several contiguous service areas and would provide a basis for:

- Development of comprehensive area rehabilitation programs in geographic service areas not served by a Massachusetts Rehabilitation Commission office.

- Analysis and evaluation of rehabilitation programs planned for service areas within the region.
- Supervision of specialized program staff to be made available in the service areas within the region.

At the present time, there are seven mental health-retardation regions. The Planning Commission recommends that the same regions be adopted for the rehabilitation service system.

Most human service agencies of the Commonwealth do not conform to the mental health-retardation regions. Although the integration of regions may be a long term process due to existing administrative patterns, eventually all human service agencies should have identical service areas and regions. The 7 administrative regions are indicated on the maps at the end of this section.

AREA PROFILES OF REHABILITATION SERVICES

An initial step in broadening of the boundaries of service systems must be the collection and interpretation of data. The Planning Commission acted to increase the relevancy of data by surveying specialized rehabilitation services and service systems. Many of these agencies previously had little involvement in rehabilitation, but could have a significant role in future comprehensive, community based rehabilitation programs. Surveys were conducted of:

- Hospitals
- Boards of Health
- Visiting Nurse Associations
- Homemaker services
- Local welfare offices
- Mental health facilities
- Social and family service agencies
- Public school systems
- Disability evaluation clinics
- Workshops

These surveys revealed that most direct service agencies such as boards of health, local welfare offices, social and family services, mental health clinics and public school systems do not provide prevocational or vocational rehabilitation services or referral to such services. Notable exceptions are listed in the area profiles. which describe relevant characteristics of each of the 37 geographic service areas from the point of view of the development of a network of rehabilitation services.

Similar results followed from surveys of stratified samples of physicians and clergymen in Massachusetts who come into close contact with potential clients of the rehabilitation system at critical points in the client's lives. Only a small percentage of the physicians and clergymen have knowledge of or use the resources of the official state rehabilitation systems.

Another finding of particular relevance to the future placement of Massachusetts Rehabilitation Commission counselors revealed that many agencies providing direct clinical services, such as local departments of welfare, boards of health and family service agencies, want a rehabilitation professional available to them for consultation and referral help.

In addition to the agencies described above, many voluntary organizations composed of disabled citizens bound together for social, recreational and/or information dissemination purposes were involved in the Planning Commission's research. Meetings with staff and questionnaires dealt with the perception of the problem faced by the handicapped individual himself in his quest towards rehabilitation. Among the self-help groups surveyed were:

- The Massachusetts Association of Paraplegics
- QT, Inc.
- Associated Blind of Massachusetts
- Indoor Sports Club of Massachusetts
- Massachusetts Association for Retarded Children
- Boston Cured Cancer Club
- Massachusetts Parents Association for the Deaf and Hard of Hearing
- Alumni Association, Hospital School at Canton
- Alumni Association, Industrial School for Crippled Children, Boston
- Mended Hearts, Peter Bent Brigham Hospital
- Massachusetts Epilepsy Society
- Massachusetts Hemophilia Association
- Massachusetts Society for Assistance to Arthritics
- United Cerebral Palsy

Most consistently, the following areas were of greatest concern to the handicapped themselves:

- Social prejudice and stereotypes creating the image that because an individual is disabled his productivity must necessarily be diminished.
- Lack of suitable housing facilities in urban areas close enough to the job market.
- Lack of transportation to get to a job which might be available.
- Delay in service provided by the official rehabilitation agencies of the state.

Independent of the nature of the disability, the communality of problems perceived seemed of particular significance. This leads to the speculation that appropriate coordination of community resources and the development of better communication between various disability groups would markedly reduce the frustrating unmet needs of the consumers of the proposed services.

DETERMINING PRIORITIES AMONG AREAS

In attempting to develop a rational method of evaluating the relative priorities for new programs among service areas, two conceptual frames of reference were utilized: the *need* for rehabilitation programs in an area and the present existence of *resources* for meeting the rehabilitation needs of the area.

Table 1

GEOGRAPHIC SERVICE AREAS RANKED BY REHABILITATION NEEDS

Geographic Service Areas	Need Indicators[1] *Population At Risk*	*Socio-Economic Status*	*Composite Ranking*[1]
Barnstable	29	16.5	24
Berkshire	23	14.5	18
Boston			
Brookline-Brighton	4	16.5	8
Government Center	8	4	3.5
Roslindale	3	9	3.5
Roxbury-North Dorchester	12	1	5
South Boston	31.5	3	15
Brockton	15	26.5	21
Cambridge	6	11	7
Concord	37	30	36.5
Danvers	7	25	12.5
Fall River	16	3	9
Fitchburg	21	23	23
Foxborough	36	31	36.5
Franklin-Hampshire	25	12.5	18
Gardner	34	12.5	26
Grafton	26	26.5	29
Haverhill	28	18	25
Hyannis	11	21	12.5
Lawrence	31.5	8	20
Lowell	10	24	14
Lynn	18	19.5	18
Malden	9	14.5	10
Medford	20	32	28
Mystic Valley	17	36.5	30
New Bedford	13	2	6
Newton	19	36.5	32
Plymouth	35	22	33
Quincy	2	28	11
Reading	27	36.5	35
Southbridge	24	19.5	22
Springfield	5	6	4.5
Taunton	30	7	16
Waltham	22	33	31
Westborough	14	34	27
Westfield	33	29	34
Worcester	1	10	1.5

[1] Each of the ranking represents the ranking of areas from 1 to 37, indicating highest to lowest need. Equivalent ranking between 2 or more areas is indicated by a tie score.

Need Defined

Need for rehabilitation services is designated in this report by two major indicators. The first is based on the estimated number of noninstitutionalized, disabled citizens below 65 years of age in each area who make up the potential clientele for rehabilitation services. Persons over 65 were not included in this need indicator because their great number (almost equal to the total population of disabled under 65) would so severely tax even the proposed new resources of the rehabilitation systems to make them functionally ineffective. Nevertheless, ultimate long-range planning in the Commonwealth must insure that adequate provision is made for this neglected population. These estimates were reached through extrapolations of data from the U.S. Bureau of the Census, National Health Survey, and from information supplied to the Planning Commission by the Massachusetts Departments of Education and Mental Health (See Appendices 2 and 3).

The second indicator of need is socioeconomic status. Three criteria for socioeconomic status were used: percentage of families with income under $3,000; rate of adults over 25 with less than 5 years of education; and rate of Aid to Families with Dependent Children recipient families for each area. These indicators, based on 1960 National Census and 1963 welfare data, are identical to those used in the Massachusetts Mental Retardation Report. Data were updated where possible and corrected for changes in geographic distribution of cities and towns among the 37 areas. The fourth socioeconomic indicator used in the Retardation Report, percentage of dilapidated-deteriorated housing, was omitted because the new boundaries of each area left a large number of communities for which the relevant data were not available. While the information is dated (1960 and 1963), it is still the most accurate and consistent material available at this time (See Appendix 4). The two dimensions were then combined into a needs ranking of each area (See Table 2).

In the past, rehabilitation services were planned on the narrower basis of the estimated numbers of disabled persons eligible for public programs. However, the two indicators mentioned above which the Planning Commission used were established without reference to eligibility for current public programs. Consequently, the scope of client service planning is significantly broadened, reflecting the Planning Commission's concern to identify need in such a manner that public and private services can attempt to meet the needs of all disabled and disadvantaged persons. (See Chart 1.)

Resource Defined

Many institutions and agencies provide rehabilitation services to some degree. However, after an intensive survey of hundreds of individual agencies, three major groups emerged where primary rehabilitation programs exist:

- General and chronic disease hospitals providing medical rehabilitation services (See Appendix 5).

Table 2

GEOGRAPHIC SERVICE AREAS RANKED BY REHABILITATION RESOURCES

Geographic Service Areas	Resource Indicators[1] Medical	Training	Education	Composite[1,2] Ranking
Barnstable	21.5	20	24	25
Berkshire	2	7	15	6
Boston				
Brookline-Brighton	1	29.5	1*	7
Government Center	6.5	29.5	1*	18
Roslindale	11	29.5	1*	13
Roxbury-North Dorchester	9	1	1*	3
South Boston	5	3	1*	1.5
Brockton	26	29.5	6	21.5
Cambridge	6.5	9	5	5
Concord	33.5	18	23	32
Danvers	16	14	11	11.5
Fall River	17	13	17.5	15
Fitchburg	18	15	8	11.5
Foxborough	35.5	16.5	14	17
Franklin-Hampshire	21.5	19	22	24
Gardner	15	21	26	13
Grafton	37	29.5	31	36
Haverhill	35.5	29.5	27.5	37
Holyoke	27	29.5	16	31
Lawrence	14	16.5	27.5	18
Lowell	10	6	30.5	14
Lynn	12.5	5	20	9
Malden	31	29.5	17.5	34
Medfield	8	11	30.5	16
Mystic Valley	33.5	12	25	29
New Bedford	29.5	8	32	28
Newton	29.5	29.5	9	27
Plymouth	20	29.5	12	21.5
Quincy	28	10	2	10
Reading	25.5	29.5	13	35
Southbridge	23.5	29.5	33	26
Springfield	4	2	[illegible]	3.5
Taunton	19	29.5	[illegible]	23
Waltham	25	19.5	4	19
Westborough	12.5	29.5	19	20
Westfield	32	29.5	10	30
Worcester	3	4	7	4

[1] [illegible]

[2] [illegible]

* [illegible]

- Sheltered workshops providing training and/or extended employment for disabled adults and young adults (See Appendix 6).
- Public schools providing prevocational and vocational services to disabled school children (See Appendix 7).

Rehabilitation services provided by other health and welfare services are essentially supplemental to these three. Any outstanding programs in a particular service area of the Commonwealth are mentioned in that area's profile description. In addition, supportive services such as recreation, transportation and housing, are just beginning to be developed and are extremely maldistributed within the state.

On the basis of surveys of hospitals, workshops and public schools conducted by the Planning Commission[1], rankings of their programs for each area were developed and provide the setting for the relative resource ranking of the service areas. (See Table 2)[2]

In Table 3, composite rankings of both needs and resources have been transformed into a chart in which both need and resource are positioned in a 5 point scale ("highest" to "lowest" need, "limited" to "major" resource).

An area's priority can be determined by reading the summary chart from the top left hand corner to the bottom right hand corner with the number in each box indicating overall relative ranking. This is based on the empirical assumption that overall need is a more powerful factor than overall resource as an indication of an area's relative position.

RANKINGS AS A STATEMENT OF PRIORITY

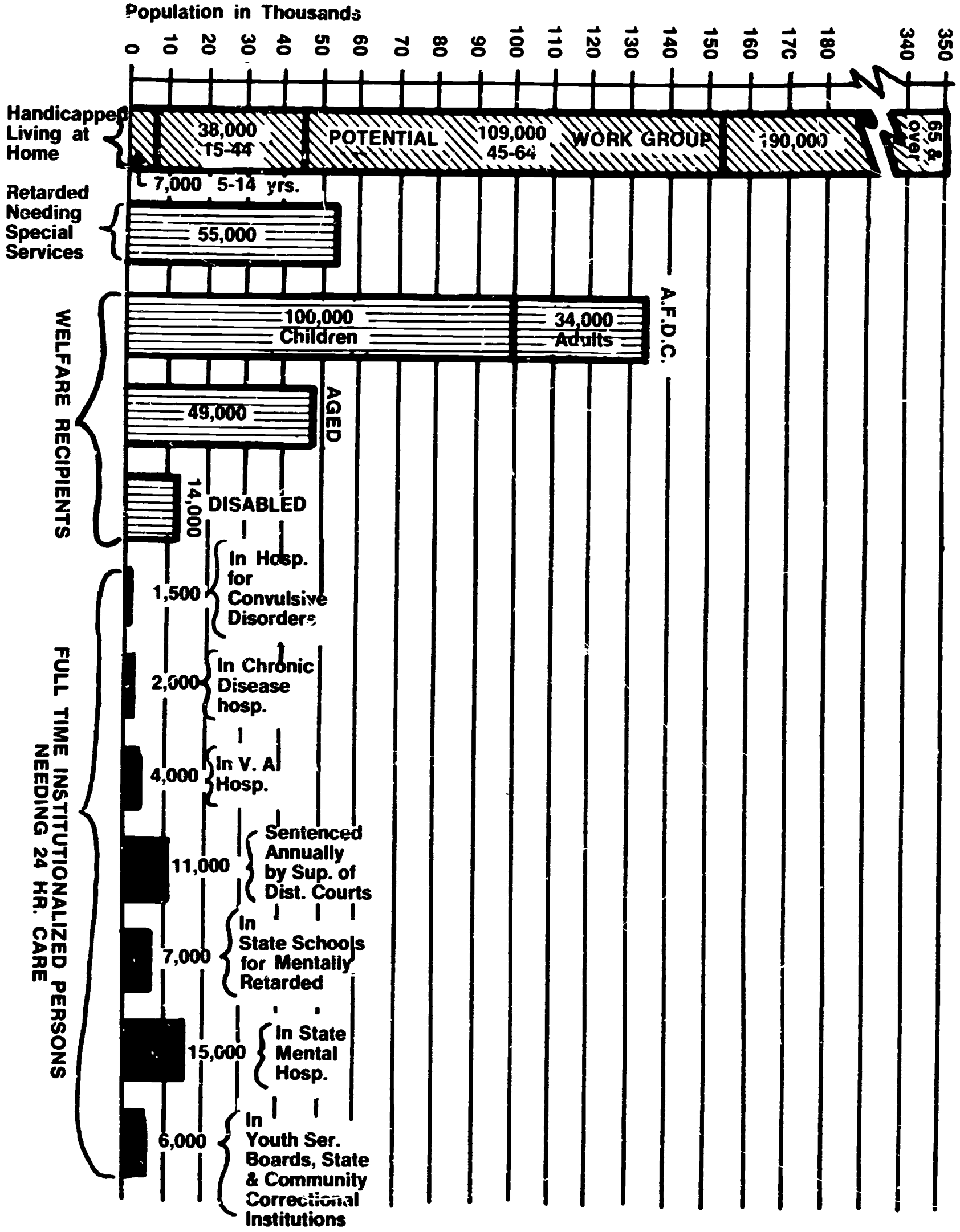
A most difficult task for planners and administrators charged with the responsibility for developing programs is to devise priorities for short and long range purposes. These rankings of rehabilitation service areas reflect the best empirical data now available. In the absence of definitive prevalence and incidence surveys, this provides a feasible and rational method for allocating resources. Area rankings should be used for designating priorities in program development by the Massachusetts Rehabilitation Commission.

As more hard data become available and as more reliable and valid indicators of rehabilitation needs and resources develop, they should be utilized for the continuing evaluation and planning of services. As the various health, welfare and rehabilitation services move toward program integration, consideration should also be given to the development of joint indicators to further broaden the scope of services measured by priority rankings.

[1]Grateful acknowledgement is made to Massachusetts Rehabilitation Commission staff members, Mrs. Roberta Habiff, Research Assistant, for her outstanding help in developing the workshop data and the hospital rankings, Mr Harvey Evans, Supervisor of Physical Restoration, for his aid in supplementing information on medical rehabilitation programs throughout the Commonwealth.

[2]A detailed account of the methodology for ranking each of these three percentages was developed and is available. Requests for copies should be made to the Research Unit, Massachusetts Rehabilitation Commission, 296 Boylston St., Boston.

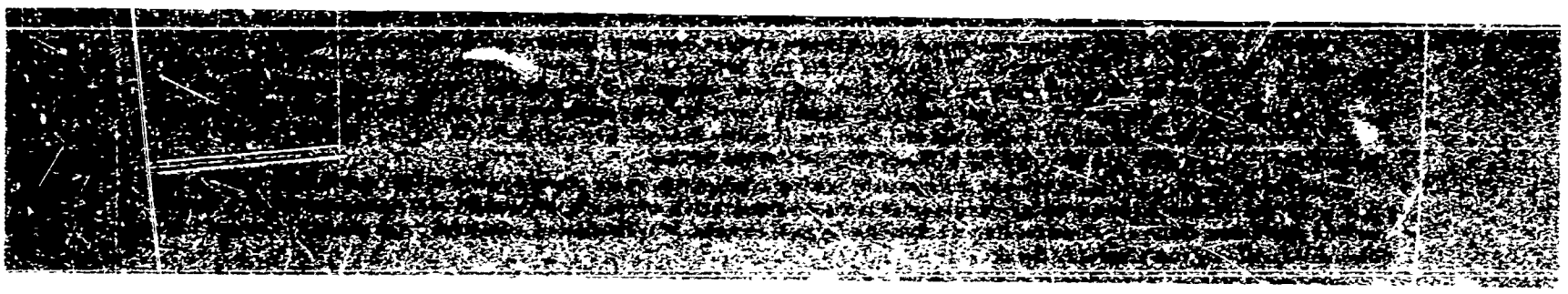
Chart 1
Disabled Population in Massachusetts*



This chart illustrates the number of disabled persons in Massachusetts living in the community or in institutions.
Prepared by: Office of Program Planning and Coordination,
Massachusetts Department of Administration and Finance, 1969

Table 3
SUMMARY CHART OF NEED-RESOURCE RANKINGS OF REHABILITATION AREAS

OVERALL NEED	OVERALL RESOURCES: Limited	Average	Major
Highest	1	2 New Bedford	3	4 Roslindale, Govt. Center	5 Roxbury-North Dorchester, Cambridge, Springfield, Worcester
AVERAGE	6 Holyoke, Malden	7	8 Fall River	Danvers, Lowell, Quincy	10 Brookline-Brighton
	11 Taunton	12 Franklin-Hampshire, Southbridge	13 Brockton, Lawrence	14 Lynn	15 Berkshire, South Boston
	16 Grafton, Haverhill	17 Barnstable, Gardner, Mystic Valley	18 Medfield, Westborough	19 Fitchburg	20
Lowest	21 Concord, Reading	22 Newton, Westfield	23 Foxborough, Plymouth, Waltham	24	25



AREA DESCRIPTIONS

In the following section, each of the 37 geographic service areas is described listing the cities and towns in the area and the major rehabilitation oriented programs and facilities. Information about these programs predominantly results from questionnaires sent by the Planning Commission to health, educational, social service and other human resource agencies throughout the Commonwealth, between January and November, 1967. Some very recent programs may be excluded, while lack of returns from some agencies, despite second and third mailings plus telephone followup, may also limit the inclusiveness of the results.

Profiles presented here supplement the needs resource rankings described earlier as a guide to the future development of comprehensive rehabilitation programs for each area. Areas are presented in alphabetical order.

BARNSTABLE

[redacted]

Barnstable, Bourne, Brewster, Chatham, Chilmark, Dennis, Eastham, East Tisbury, Falmouth, Gayhead, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Sandwich, Tisbury, Truro, Wareham, Wellfleet, Yarmouth

[redacted]

- Cape Cod Hospital, Hyannis
- Falmouth Hospital
- Parents' School for Atypical Children, Inc., Chatham

This major resort area is made up of 23 towns including Cape Cod and the Islands. In the summer months, the population of the area greatly increases. Public transportation facilities, other than private vehicles, present a significant limitation to the handicapped.

Cape Cod Hospital in Hyannis is the area's largest medical facility with some physical and occupational therapy service and a staff social worker. Falmouth Hospital has a contractual agreement with the Easter Seal Society to provide physical and occupational therapy through the Association's traveling team. Limited physical therapy services are also provided at the Martha's Vineyard Hospital, Oak Bluffs Hospital, the Nantucket Cottage Hospital, and the Barnstable County Hospital in Pocasset. There is no comprehensive medical rehabilitation institution in the area.

Barnstable, Brewster, Dennis, Mashpee and Yarmouth, as members of the District Nurse Association in Hyannis, are provided with physical and occupational therapy services. There is a notable lack of such services north of Orleans. Homemakers represent the only service provided to homebound clients in Martha's Vineyard. A full range of at home rehabilitation services is provided by the Visiting Nurse Association in Wareham. However, that town is geographically and historically unconnected to the other communities composing the area. The island of Nantucket has no rehabilitation services whatsoever.

Provincetown Welfare Department alone has the services of a vocational rehabilitation consultant available to its staff. The Parent's School for Atypical Children, Inc., in Chatham, is a small private institution offering limited work adjustment groups to a small number of retarded clients.

Falmouth school system offers a prevocational training program while Barnstable, Bourne, Falmouth and Provincetown provide a variety of limited vocational training programs. All of these programs are restricted to the mentally retarded child with the exception of Bourne which also does some training of physically handicapped students.

A Massachusetts Rehabilitation Commission subdistrict office in Hyannis covers all communities except Wareham, which is served by the New Bedford office. The area is also served by the Hyannis and New Bedford offices of the Division of Employment Security.

BERKSHIRE

[redacted]

Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mt. Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor

[redacted]

- Alcoholism Clinic, Pittsfield General Hospital
- Austen Riggs Center, Inc., Stockbridge
- Berkshire County Association Workshop for Retarded Children, Pittsfield
- Berkshire Rehabilitation Center, Inc., Pittsfield General Hospital
- Fairview Hospital, Great Barrington
- Goodwill Industries of Pittsfield
- Gould Farm, Great Barrington
- Hillcrest Hospital, Pittsfield
- North Adams Hospital
- Opportunities for the Handicapped, Pittsfield
- Pittsfield Workshop for the Blind
- St. Luke's Hospital, Pittsfield
- United Cerebral Palsy Association of Berkshire County, Inc., Pittsfield
- W. B. Plunkett Memorial Hospital, Adams

The Berkshire area includes all 32 cities and towns comprising Berkshire County, with Pittsfield and North Adams as the two most populated areas. Generally, however, rural isolation hampers accessibility and the utilization of available resources.

All six general hospitals in the area have some rehabilitation services. The most inclusive is the Berkshire Rehabilitation Center, Inc., located at the Pittsfield General Hospital. This center is the only facility in western Massachusetts to provide comprehensive rehabilitation services including combined medical rehabilitation evaluation, occupational and physical therapy, social services, speech and hearing services, and vocational evaluation and counseling. Satellite teams from this center travel to and provide rehabilitation services for St. Luke's and Hillcrest Hospitals in Pittsfield and Fairview Hospital in Great Barrington. North Adams Hospital and the W. B. Plunkett Memorial Hospital in Adams both have limited physical therapy services.

Fourteen of the communities in the area are served by nursing associations, which provide twelve of the communities with limited physical therapy services. Nine contiguous communities in the southeast section of the area are notably lacking in any home health services. The Alcoholism Clinic established within the Pittsfield General Hospital provides limited vocational programs in the form of vocational testing and referrals to selected clients.

With the exception of two district welfare offices which have a consulting vocational rehabilitation specialist available and consequent referral services, local welfare departments provide no specific rehabilitation aid. Two family and children's service agencies operate in the area, one in North Adams, the other in Pittsfield, with the latter providing some vocational testing and counseling.

The Pittsfield school system provides prevocational and vocational training programs to physically and mentally disabled students at the high school level. Adams, Lee, and North Adams offer a number of limited programs to retarded and handicapped persons, while Stockbridge and West Stockbridge make arrangements with other school systems for such training.

Four special disability facilities function in the area. Austen Riggs Center, Inc., in Stockbridge, provides psychiatric diagnosis and evaluation, psychological therapy and occupational therapy for both inpatients and outpatients on a private basis and with limited capacity. Gould Farm in Great Barrington is a residential setting which offers counseling and occupational therapy for mentally ill patients. In Pittsfield, the United Cerebral Palsy Association of Berkshire County, Inc., offers physical, occupational, and speech therapy; and a nonsectarian program called Opportunities for the Handicapped, located in the Unitarian Church, Pittsfield, provides arts and crafts activities for severely mentally retarded persons.

There are three workshops in the area, all located in Pittsfield. Goodwill Industries, Inc., provides comprehensive vocational services to approximately 40 clients per year with all types of disabilities. Berkshire County Association Workshop for Retarded Children provides limited services as a single disability workshop to up to 15 clients annually. Pittsfield Workshop for the Blind offers extended employment to six male clients.

The area is served by the Massachusetts Rehabilitation Commission office and the Division of Employment Security offices in Pittsfield and North Adams.

BOSTON

Two kinds of data were amassed in connection with the Boston area. The first category involves those facilities which are able to be divided by catchment areas such as hospitals and rehabilitation centers. Due to the nature of the second type of information, that which is generic to all of Boston (welfare, social, family and educational services), a general picture of the city is presented, for this data, adding specific towns in Boston-related areas. The five catchment areas comprising Boston and selected contiguous communities are listed below in alphabetical order. It should be noted that the area name, which in the Massachusetts Mental Health and Massachusetts Mental Retardation Planning Project Reports, designated the major Mental Health-Mental Retardation Institution in each area, has been changed to correspond to the major geographic segment of the community which it represents. In this way, they are brought into greater harmony with the other area descriptive titles.

GENERIC RESOURCES IN BOSTON

The Visiting Nurse Association of Boston is a major health agency, providing complete home nursing services such as physical therapy and occupational therapy, to homebound clients throughout the city of Boston. The Welfare Department of Boston is developing a program of inservice training for staff in job evaluation and job placement for clients in conjunction with the Massachusetts Rehabilitation Commission.

Both the Jewish Family and Children's Service and the New England Home for Little Wanderers offer vocational counseling, placement, and followup to their clients Of the many social service agencies in Boston, only a few appear to offer significant vocational rehabilitation services. Crittenton Hastings House provides vocational counseling and testing to a limited number of unwed mothers. Salvation Army Correctional Service Bureau offers sheltered work experience to most of its male clients.

Mentally retarded students receive prevocational training throughout all grade levels and vocational training at the junior high and high school levels. No prevocational or vocational training is systematically offered in the Boston school system to physically handicapped and emotionally disturbed children. Within the state of Massachusetts, Boston is unique in having 24 private trade schools, most of which offer specialized training, scattered throughout the city.

BROOKLINE - BRIGHTON

[redacted]

Back Bay (census tracts K4A, K4B, J7, S1),
Brighton, Brookline, Jamaica Plain,
Roxbury (census tracts S2, S4, S5, S6, V2)

[redacted]

- Beth Israel Hospital, Boston
- Boston Aid to the Blind, Inc.
- Boston Center for Blind Children, Roxbury
- Children's Hospital Medical Center, Roxbury
- Faulkner Hospital, Jamaica Plain
- Horace Mann School for the Deaf, Ear Clinic Department, Roxbury
- Jewish Memorial Hospital, Roxbury
- Joseph P. Kennedy, Jr., Memorial Hospital, Brighton
- Lemuel Shattuck Hospital, Jamaica Plain
- Massachusetts Mental Health Center, Roxbury
- New England Baptist Hospital, Roxbury
- New England Deaconess Hospital, Boston
- Northeastern University Speech and Hearing Clinic, Boston
- Peter Bent Brigham Hospital, Roxbury
- Robert Breck Brigham Hospital, Roxbury
- St. Elizabeth's Hospital, Brighton
- Salvation Army Men's Social Service Center, Boston
- Veterans Administration Hospital, Boston
- Washingtonian Hospital, Jamaica Plain

The western section of greater Boston and the town of Brookline comprise this area. The area is most abundantly endowed with medical facilities which provide a full range of rehabilitation services. The Massachusetts Mental Health Center offers rehabilitation, occupational therapy, and social services with an emphasis on outpatients. Beth Israel Hospital provides comprehensive medical rehabilitation services, including physical medicine and rehabilitation departments. Physical therapy and social services are offered at the Peter Bent Brigham Hospital in Roxbury, St. Elizabeth's Hospital in Brighton, and Faulkner Hospital in Jamaica Plain. New England Deaconess Hospital in Boston, and New England Baptist Hospital in Roxbury provide social services. Comprehensive services are provided at the state run Lemuel Shattuck Hospital, in Jamaica Plain, including a full time vocational rehabilitation specialist; the Joseph P. Kennedy, Jr. Memorial Hospital in Brighton, a pediatric hospital; and the Veteran's Administration Hospital in Boston. Rehabilitation services in physical medicine and social service departments are offered at the Jewish Memorial Hospital in Roxbury. Robert Breck Brigham Hospital, a chronic disease institution, in Roxbury, and the Washingtonian Hospital, Jamaica Plain, a private specialized medical and psychiatric treatment center for alcoholism, provide physical therapy and social services, while Children's Hospital Medical Center provides an extensive and comprehensive rehabilitation program.

Physical therapy and homemaker services are provided by the Brookline Visiting Nurse Association through a contract with the Inter-Community Homemaker Service. Rehabilitation programs offered by the Brookline Department of Welfare include referral services to official state agencies, and vocational evaluation of appropriate welfare applicants.

Mentally retarded children are given prevocational training in the Brookline school system, while retarded and emotionally disturbed children are offered vocational training.

Two major speech and hearing facilities are located in this area: The Northeastern University Speech and Hearing Clinic for outpatient services and the Ear Clinic Department of the Horace Mann School for the Deaf, a city owned teaching facility in Roxbury. Other special agencies include the Boston Aid to the Blind, Inc., with a program of social, recreational and informal education for blind and visually handicapped persons; the Boston Center for Blind Children in Roxbury, offering diagnostic services and treatment of emotionally disturbed blind children and the Cerebral Palsy Unit at the Children's Hospital Medical Center.

Special rehabilitation facilities are located at the Salvation Army Men's Social Service Center in Boston, with services such as vocational evaluation and counseling, personal adjustment training, prevocational and vocational training, on-the-job training, and job placement and extended employment.

A newly created Massachusetts Rehabilitation Commission office is located in the Roxbury area; there is no Division of Employment Security Office

GOVERNMENT CENTER

Cities and Towns

Charlestown, Chelsea, East Boston, North End, Revere, West End, Winthrop,

Major Rehabilitation Resources

- Grover Manor Hospital, Revere
- Lawrence F. Quigley Memorial Hospital, Chelsea
- Massachusetts General Hospital, Boston
- North Bennet Street Industrial School, Boston
- Revere Memorial Hospital
- Veterans Administration Outpatient Clinic, Veterans Administration Hospital, Boston

The Government Center area includes the West and North Ends of Boston as well as Charlestown, East Boston, Winthrop, Chelsea, and Revere.

Grover Manor and Revere Memorial Hospitals provide limited physical therapy services. Lawrence F. Quigley Memorial Hospital, in Chelsea, has an active physical medicine program for veterans. The Massachusetts General Hospital has two major rehabilitation units: the Department of Physical Medicine, providing physical and occupational therapy, social services and a unique prevocational evaluation program; and the Rehabilitation Unit, offering comprehensive physical and occupational therapy, and social services.

Two speech and hearing centers are located in this area. Massachusetts Eye and Ear Infirmary provides extensive speech and audiological services to approximately 2,500 patients a year. The Veteran's Administration Outpatient Clinic offers a full range of audiological services to outpatient veterans.

Visiting Nurse Associations in Chelsea and Winthrop offer physical therapy services to disabled clients, while the Revere Visiting Nurse Association offers similar services on a consultant basis. Inservice training of personnel concerning job evaluations for their clients is provided by the Chelsea welfare department.

Mentally retarded students receive some prevocational and vocational training at an ungraded level in the Chelsea school system. Similar training is offered by the Winthrop school system to emotionally disturbed, retarded, and physically handicapped children.

North Bennet Street Industrial School, in Boston, provides vocational evaluation and training to approximately 135 persons with mental and orthopedic disorders, annually.

A Massachusetts Rehabilitation Commission office is located within the Government Center area.

ROSLINDALE

Cities and Towns

Dorchester Central (census tracts T5B, T7B, T8A, T8B, T9, T10, X1), Dorchester South, Hyde Park, Roslindale, West Roxbury

Major Rehabilitation Resources

- Patient Rehabilitation Occupational Program Workshop, Boston State Hospital, Dorchester
- Carney Hospital, Dorchester
- Hebrew Rehabilitation Center for the Aged, Roslindale
- Mattapan Chronic Disease Hospital
- West Roxbury Veterans Administration Hospital

This area includes the southeastern section of the city of Boston.

Carney Hospital in Dorchester provides rehabilitation through physical therapy and social service. Previously known as the Boston Sanatorium, Mattapan Chronic Disease Hospital has an extended care unit for Boston City Hospital plus a halfway house for tubercular and alcoholic patients, providing physical and occupational therapy and social services. A combination rehabilitation and physical medicine department provides comprehensive programs at the West Roxbury Veterans Administration Hospital. Occupation, physical and work diversional therapy are offered by the physical medicine, social service and rehabilitation departments at the Hebrew Rehabilitation Center for the Aged.

In cooperation with the Boston State Hospital, the Patient Rehabilitation Occupational Program, Inc., operates a transitional and extended employment workshop for approximately 125 mental patients annually. Another workshop is located on the grounds of the Mattapan Chronic Disease Hospital, serving inpatients, outpatients, and those men from the halfway house for tubercular alcoholics with prevocational training programs.

This entire area is covered by the Massachusetts Rehabilitation Commission and the Division of Employment Security offices outside of the area in Boston.

ROXBURY - NORTH DORCHESTER

Cities and Towns

Back Bay (census tracts J3, J4, K3, K5),
Dorchester North (census tracts P2, P3, P4, P5, P6, Q5, T3A, T3B, T6, T7A),
South End (less census tracts G1, G2, G3, G4),
Roxbury (census tracts S2, S4, S5, S6, V2)

Major Rehabilitation Resources

- Boston City Hospital
- Boston Guild for the Hard of Hearing
- Deaf Adult Program, Noyes Rehabilitation Center, Morgan Memorial, Goodwill Industries, Boston
- Industrial School for Crippled Children, Boston
- New England Hospital, Roxbury
- Morgan Memorial Goodwill Industries, Boston
- Rehabilitation Center, Liberty Mutual Insurance Co., Boston
- Robbins Speech and Hearing Clinic, Boston
- University Hospital, Boston

This area encompasses the north central section of Boston, including parts of Back Bay, the South End, and the western portion of North Dorchester.

Boston City Hospital has a physical medicine department limited to physical therapy and social service. University Hospital's large medical complex is part of Boston University Medical Center and has a combined rehabilitation and physical medicine department offering comprehensive services. Located in the Boston Model City Area, the New England Hospital in Roxbury offers physical therapy and social services.

Robbins Speech and Hearing Center in Boston provides speech and hearing evaluations and training to 500 patients yearly. Another audiological facility is the Boston Guild for the Hard of Hearing, providing diagnosis, hearing and speech therapy services to approximately 2,000 persons per year. Also located in the area is the Industrial School for Crippled Children for the physically handicapped, from grades one through seven. Operated by Morgan Memorial, Goodwill Industries, Inc., on a joint sponsorship with the Social Rehabilitation Service, the Deaf Adult Program provides vocational rehabilitation services to approximately 10 young deaf adults within the framework of a multidisability center.

A medical and vocational rehabilitation facility, sponsored by the Liberty Mutual Insurance Company provides comprehensive outpatient services, such as medical rehabilitation evaluation and counseling, occupational and physical therapy, and personal adjustment to disabled clients of the company's insured. The largest facility in the state, Morgan Memorial Goodwill Industries serving greater Boston and the suburbs, annually offers 1,750 patients of all disabilities medical, social, psychological, and vocational evaluations in addition to vocational training and extended employment.

Massachusetts Rehabilitation Commission offices covering this area are located in Roxbury and in the Government Center area. The entire area is served by the Division of Employment Security in Boston.

SOUTH BOSTON

Cities and Towns

Dorchester North (census tracts T1, T4A, T4B, T5A, P1C, TA, P1A, P1B),
South Boston, South End (census tracts G1, G2, G3, G4)

Major Rehabilitation Resources

- Community Workshops, Inc., Boston
- Jewish Vocational Service Work Center, Boston
- New England Rehabilitation for Work Center, Boston
- Tobin Renabilitation Center for Alcoholics, Long Island Hospital, Boston
- Vocational Adjustment Center, South Boston
- Tufts New England Medical Center, Boston

This area is comprised of South Boston, and parts of North Dorchester and the South End.

Tufts New England Medical Center, including the Boston Dispensary, is a major rehabilitation complex in the area, with 30 specialty clinics and an extensive home care program; the Rehabilitation Institute, the Boston Floating Hospital for Infants and Children; the Pratt Clinic and Diagnostic Hospital and New England Center Hospital. Comprehensive medical rehabilitation services are provided at the Department of Physical and Rehabilitation Medicine, including rehabilitation evaluation, occupational and physical therapy, psychiatric, speech, hearing and social services. Columbia Point Health Center, Dorchester, is also operated by the Tufts New England Medical Center. Associated with the Boston City Hospital, Tobin Rehabilitation Center for Alcoholics, located at the Long Island Chronic Disease Hospital in Boston Harbor, provides physical and occupational therapy and social services.

The Speech, Hearing and Language Center at Tufts New England Medical Center offers extensive speech and hearing services to approximately 2,400 patients per year.

Rehabilitation services are provided for 75 retarded clients annually in transitional and extended employment programs at the Vocational Adjustment Center, South Boston, operated by the Boston Association for Retarded Children. Both the multidisability Community Workshops, Inc., in Boston and the Jewish Vocational Service Work Center provide a full range of workshop services to 230 and 70 clients yearly. Also located in this area is the New England Rehabilitation Work Center, operated by Morgan Memorial, providing evaluation and adjustment services to 115 clients annually.

Massachusetts Rehabilitation Commission and the Division of Employment Security offices are located outside the area in Government Center and in Roxbury.

BROCKTON

Cities and Towns

Abington, Avon, Brockton, East Bridgewater, Easton, Holbrook, Rockland, Stoughton, West Bridgewater, Whitman

Major Rehabilitation Resources

- Brockton Hospital
- Brockton Veterans Administration Hospital
- CHIRP Workshop, Brockton
- Goddard Medical Associates, Goddard Memorial Hospital, Stoughton

Located 25 miles south of Boston, the Brockton area is comprised of 12 communities with the industrialized center of Brockton as its major city.

The large Brockton Veterans Administration Hospital provides quite comprehensive rehabilitation services of all types to veterans. Brockton Hospital provides limited rehabilitation services in a small physical therapy unit, while Goddard Medical Associates, affiliated with the Goddard Memorial Hospital in Stoughton, provides physical therapy services and medical rehabilitation examinations.

All the communities in the area except West Bridgewater receive physical therapy services from either the Brockton Visiting Nurse Association or from local health agencies, while Brockton also has a homemaker service.

Easton and Whitman presently provide the most complete vocational services to welfare applicants. Both have available a vocational rehabilitation consultant and furnish inservice training to staff in job evaluation and placement as well as vocational evaluation of welfare applicants. Brockton Family Service Association counsels clients referred by the Massachusetts Rehabilitation Commission.

Retarded students in Brockton, Easton and Rockland school systems receive a variety of prevocational and vocational programs, while limited programs exist in the Holbrook and Stoughton systems. Avon, Abington, and Stoughton make arrangements for special education of their handicapped children in the outside areas of Randolph, Quincy, and Milton.

The only special vocational rehabilitation facility in the area is the Community Hospital Industrial Rehabilitation Placement (CHIRP) workshop under the Brockton Veterans Administration Hospital, which offers a full range of medical and vocational rehabilitation services to approximately 520 veterans annually with neuro-psychiatric disabilities.

The entire area is served by the Massachusetts Rehabilitation Commission and the Division of Employment Security offices in Brockton.

CAMBRIDGE

[redacted]

Cambridge, Somerville

[redacted]

- Brusch Medical Center, Cambridge
- Cambridge City Hospital
- Cambridge Workshop for the Blind
- Holy Ghost Hospital, Cambridge (Cardinal Cushing Rehabilitation Center)
- Mt. Auburn Hospital, Cambridge
- Wellmet Project, Inc., Cambridge

This area is situated contiguously north of Boston and includes the major cities of Cambridge and Somerville.

Extensive medical rehabilitation services are provided at the Holy Ghost Hospital and its Cardinal Cushing Rehabilitation Center in Cambridge, a major chronic disease facility. Physical therapy services for outpatients, and social services are provided at the Mt. Auburn Hospital in Cambridge. Only social services are offered at Cambridge City Hospital. Limited physical therapy services are furnished at the Somerville Hospital, the Central Hospital in Somerville and the Sancta Maria Hospital in Cambridge.

Social services, provided by the Cambridge Health Department, are the only other medical rehabilitation services in the area. Two mental health facilities provide direct vocational services, the Brusch Medical Center, a private clinic offering some vocational counseling, and the Wellmet Project, Inc., a Harvard University cooperative house which helps its members to locate jobs.

Consulting services of a vocational rehabilitation specialist are made available to the Somerville Welfare Department through the Massachusetts Rehabilitation Commission. Cambridge Welfare Department sponsors a Work Experience Program for recipients of Aid to Families with Dependent Children. Through this program, a professional vocational expert is available, as is inservice training for staff in job evaluation and placement. Caravan Society for Children in Somerville operates a resident summer program for physically handicapped children.

Though neither the Cambridge nor the Somerville school system offers vocational services to physically handicapped students, both have comprehensive prevocational and vocational programs beginning in the elementary or junior high years for mentally retarded children. The Cambridge system is presently experimenting with the extension of some vocational services to the emotionally handicapped.

Extended employment services are provided for up to 80 clients a year at the state operated Cambridge Workshop for the Blind.

This area is covered by the Massachusetts Rehabilitation Commission district office in Somerville and two Division of Employment Security offices (Somerville and Cambridge).

CONCORD

Cities and Towns

Acton, Bedford, Boxboro,
Carlisle, Concord, Harvard, Lincoln,
Littleton, Maynard, Stow

Major Rehabilitation Resources

- Bedford Veterans Administration Hospital, Veterans Administration Workshop
- Emerson Hospital, Concord
- Minute Man Shop, Concord
- Valley Head Hospital, Carlisle

The Concord area consists of 10 communities located approximately 15 miles west of Boston, with Bedford and Concord being the largest cities within the area.

Rehabilitation facilities at the Bedford Veterans Administration Hospital include a physical medicine and rehabilitation department and a counseling psychology service. These departments provide medical rehabilitation and speech evaluation, occupational and physical therapy, vocational counseling and a workshop. Physical therapy services are provided at the Emerson Hospital in Concord and occupational therapy services at the Valley Head Hospital in Carlisle. Limited physical therapy and social services are provided by area boards of health and other health agencies.

Vocational services at the high school level are provided by the Bedford school system to its emotionally and physically handicapped students. In the Maynard school system, both junior high level prevocational and high school level vocational programs are offered to physically handicapped persons. Lincoln, Bedford, Acton and Harvard make arrangements with other school systems to care for their disabled students.

Bedford Veterans Administration Hospital has a workshop serving up to 140 patients daily with extensive vocational rehabilitation programs. Sponsored by the Minute Man Association for Retarded Children, Inc., the Minute Man Shop in Concord serves up to 8 severely retarded persons a day and provides limited prevocational services and extended employment.

All Massachusetts Rehabilitation Commission offices are located outside the area, in Worcester, Somerville or Lowell. Division of Employment Security offices are also located outside the area in Marlboro, Woburn, Fitchburg, Lowell, and Waltham.

DANVERS

Cities and Towns

Beverly, Danvers, Essex, Gloucester,
Hamilton, Ipswich, Manchester,
Rockport, Middleton, Peabody,
Salem, Topsfield, Wenham

Major Rehabilitation Resources

- Beverly Hospital
- Beverly School for the Deaf
- Danvers State Hospital, North Shore Sheltered Workshop
- Gilbert Hospital, Gloucester
- Hunt Memorial Hospital, Danvers
- Josiah B. Thomas Hospital, Peabody
- Salem Hospital
- Cerebral Palsy Association, Salem
- Heritage Training Center, Salem

Comprised of 14 cities and towns, the Danvers area is located on the shore north of Boston.

Salem Hospital and the Josiah B. Thomas Hospital in Peabody provide physical therapy and social services. Beverly Hospital offers the same, as well as part time occupational therapy. Hunt Memorial Hospital in Danvers, and Addison Gilbert Hospital in Gloucester provide small physical therapy departments. At present, comprehensive rehabilitation services are lacking in the area.

Physical therapy services are provided to each community through various visiting nurse associations except the towns of Gloucester, Rockport and Topsfield. Occupational therapy is offered by the Manchester and Marblehead Visiting Nurse Associations. Danvers and Marblehead Visiting Nurse Associations and Peabody Board of Health provide speech therapy on an on call basis. Rockport Public Health Nursing Society furnishes the only homemaker service for the area. Danvers State Hospital furnishes hospital industry jobs and job placement programs for its inpatients.

Welfare departments of Beverly, Ipswich, Middleton and Salem make vocational evaluations of their welfare applicants.

Prevocational and vocational training programs are offered in Beverly, Marblehead, and Peabody school systems to mentally retarded students. Similar training in Ipswich and Topsfield schools are offered to both retarded and emotionally handicapped persons.

Beverly School for the Deaf provides an academic program, auditory and lip reading training, speech evaluations and prevocational training for children with a hearing loss between the ages of 4 and 18. In Salem, the Cerebral Palsy Association provides up to 62 clients a year with physical therapy, speech and audiological evaluations and therapy as well as a recreational program.

At the Danvers State Hospital, the North Shore Sheltered Workshop provides extensive vocational rehabilitation services and transitional employment to about 40 clients, while the Heritage Training Center in Salem, sponsored by the North Shore Association for Retarded Children, Inc., serves 30 clients a year with vocational evaluation and training, transitional and extended employment.

The Massachusetts Rehabilitation Commission office in Lynn serves the area as do the Division of Employment Security offices in Salem, Gloucester and Newburyport.

FALL RIVER

Cities and Towns

Fall River, Freetown, Somerset,
Swansea, Westport

Major Rehabilitation Resources

- Bristol County Mental Health Clinic, Fall River
- Earle E. Hussey Hospital, Fall River
- Fall River Rehabilitation Center
- Greater Fall River Association for Retarded Children Workshop
- Truesdale Hospital, Fall River
- Union Hospital, Fall River

This area includes the industrial center of Fall River and four smaller, suburban communities.

Union Hospital serves both in and outpatients through a large physical therapy department and social services. Earle E. Hussey Hospital, a chronic disease facility, has physical therapy and occupational therapy services for its inpatients, while Truesdale Hospital has a small physical therapy department.

Physical therapy services are also provided by local boards of health or visiting nurse associations in all area communities except the smallest, Freetown. Limited vocational counseling and referral services are rendered by the Bristol County Mental Health Clinic of Fall River.

Stevens Home for Boys and the Deaconness Home Child Care Center in Fall River provide limited vocational counseling services.

Prevocational and vocational public school programs for retarded students are available in all area communities, except Somerset.

Fall River Rehabilitation Center provides an array of diagnostic and therapeutic services for all types of disabilities except blindness, although special emphasis is placed on rehabilitation programs for cerebral palsied clients. Greater Fall River Association for Retarded Children Workshop provides basic work adjustment and activity for up to 19 children a year.

The area is served by the Fall River Division of Employment Security office, but the nearest office of the Massachusetts Rehabilitation Commission is presently in New Bedford.

FITCHBURG

Cities and Towns

Ashby, Ayer, Berlin, Bolton, Clinton,
Fitchburg, Groton, Lancaster, Leominster, Lunenberg,
Pepperell, Shirley, Sterling, Townsend

Major Rehabilitation Resources

- Burbank Hospital, Fitchburg
- Leominster Hospital
- Nashoba Community Hospital, Ayer
- North Worcester County Association for Retarded Children and United Fund Workshop, Fitchburg

The Fitchburg area, composed of 14 communities, is located in the north-central part of Massachusetts.

Burbank Hospital in Fitchburg offers some rehabilitation services in its physical and occupational therapy, and social service departments. Leominster Hospital has a small physical therapy department with limited equipment. Nashoba Community Hospital in Ayer contracts rehabilitation services through the Easter Seal Society's Traveling Team which provides occupational, physical and speech therapy, as well as social services on a part time basis.

Fitchburg Visiting Nurse Association contracts a broad range of rehabilitation services from the Easter Seal Society while the Leominster Visiting Nurse Association provides physical therapy on a part time basis to homebound clients.

In addition to referring clients to the various official state rehabilitation agencies, the Ayer and Clinton welfare departments provide vocational evaluation to their applicants.

Ayer and Sterling school systems offer prevocational training programs to retarded students, while the Fitchburg system has vocational training programs beginning at the grade school level for the retarded. Leominster, Pepperell, and Townsend offer a variety of prevocational and vocational training programs, beginning at the junior high and high school levels, to physically handicapped and retarded persons.

The only predominantly rehabilitation-oriented facility in the area is the North Worcester County Association for Retarded Children and United Fund Workshop in Fitchburg, a small sheltered workshop serving up to 25 trainable clients annually. Perkins School located in Lancaster is a residential teaching facility for retarded persons, serving 95 students per year with limited rehabilitation services such as speech therapy and prevocational training.

The area is served by the Massachusetts Rehabilitation Commission offices in Fitchburg, Worcester and Lowell. Division of Employment Security offices in Fitchburg, Marlboro and Worcester also serve the communities.

FOXBOROUGH

Cities and Towns

Attleboro, Foxborough, Mansfield,
North Attleboro, Norton

Major Rehabilitation Resources

- Attleboro Area Association for Retarded Children Workshop
- Foxboro State Hospital
- Sturdy Memorial Hospital, Attleboro

The Foxborough area, composed of five rural communities, is located southwest of Boston and borders on the eastern state line of Rhode Island.

Sturdy Memorial Hospital in Attleboro has a social service department and provides physical therapy services. Also in Attleboro, the Fuller Memorial Sanatorium, a small private psychiatric hospital, provides social service and physical medicine departments with both physical and occupational therapy, while the Foxborough State Hospital is expanding its inpatient rehabilitation program.

The local Visiting Nurse Association at Foxborough provides physical and occupational therapy and social services to homebound clients. The four remaining communities receive physical therapy services only through the Visiting Nurse Association in Attleboro.

Attleboro Welfare Department provides vocational evaluation to selected applicants.

Mansfield, North Attleboro and Norton offer some vocational programs in their school systems for mentally retarded students beginning at the elementary or junior high level.

The only rehabilitation facility in the area is a small workshop, the Attleboro Area Association for Retarded Children Workshop, serving eight clients annually with a work program but no formal work evaluation.

Brockton Massachusetts Rehabilitation Commission office serves the area. The Division of Employment Security office at Attleboro serves all the towns except Norton, which is covered by the Taunton office.

FRANKLIN - HAMPSHIRE

Cities and Towns

Amherst, Ashfield, Bernardston, Buckland,
Charlemont, Chesterfield, Colrain, Conway,
Cummington, Deerfield, Erving, Gill,
Goshen, Greenfield, Hadley, Hatfield,
Hawley, Heath, Leverett, Leyden,
Middlefield, Monroe, Montague, Northampton,
Northfield, Pelham, Plainfield, Rowe,
Shelburne, Sh· tesbury, Sunderland, Wendell,
Westhampton, Whately, Williamsburg, Worthington

Major Rehabilitation Resources

- Cooley Dickinson Hospital, Northampton
- Clarke School for the Deaf, Northampton
- Department of Speech,
  University of Massachusetts at Amherst
- Farren Memorial Hospital, Montague
- Franklin County Association Workshop
  for Retarded Children, Greenfield
- Franklin County Hearing and Speech Center, Inc., Greenfield
- Franklin County Mental Health Center, Greenfield
- Franklin County Public Hospital, Greenfield
- Northampton State Hospital Sheltered Workshop
- Veterans Administration Hospital, Northampton

Thirty-six rural towns in this area are located in the mountainous northern and western regions of Massachusetts. The area borders Vermont on the north and the Connecticut River splits the territory from north to south.

Franklin County Public Hospital in Greenfield serves the entire area with a rehabilitation unit which includes physical and occupational therapy and social service departments. In addition, the hospital has applied for funds for expansion of present rehabilitation services. Physical therapy services are provided at the Farren Memorial Hospital in Montague and the Cooley Dickinson Hospital in Northampton.

The Veterans Administration Hospital offers comprehensive rehabilitation services. In addition to physical therapy, occupational therapy, social services and speech and hearing departments, the hospital offers personal adjustment training, vocational evaluation and counseling, prevocational training and job placement.

A heavy concentration of physical rehabilitation services exists in the northeastern section of the area, with the Visiting Nurse Association in Greenfield as the main donor. The only other rehabilitation facilities in the area, except for physical therapy and limited social services, are provided to several communities along the southern border of the area, by various boards of health and visiting nurse associations. Franklin County Mental Health Center provides some vocational testing and counseling, while a sheltered workshop for inpatients has been developed by the Northampton State Hospital.

The only vocational training programs in public school systems in this area are for retarded students, although there are many other handicapped persons of school age. Three specific facilities for the deaf are located in the area, providing speech and hearing evaluation and therapy: The Clarke School for the Deaf in Northampton; the Franklin County Hearing and Speech Center, Inc., in Greenfield; and the Department of Speech at the University of Massachusetts in Amherst.

A single disability workshop, the Franklin County Association Workshop for Retarded Children, provides approximately 13 clients annually with an arts and crafts program. However, no formal evaluation or training programs are offered.

All communities are served by the Massachusetts Rehabilitation Commission offices within the Greenfield or Springfield area. All but Erving, Middlefield, Monroe and Wendell are served by the Division of Employment Security offices within the area in Greenfield and Northampton.

GARDNER

Cities and Towns

Ashburnham, Athol, Barre, Gardner,
Hardwick, Hubbardston, New Braintree, New Salem,
Oakham, Orange, Petersham, Phillipston,
Princeton, Royalston, Rutland, Templeton,
Warwick, Westminster, Winchendon

Major Rehabilitation Resources

- Devereaux Foundation, Rutland
- Gardner-Athol Area Mental Health Workshop, Gardner State Hospital
- Greater Gardner Association for Retarded Children Workshop
- Heywood Memorial Hospital, Gardner
- Rutland Heights Hospital
- Rutland Heights Mental Health Rehabilitation Center

The Gardner area, located in the north-central region of the state, is composed of 19 cities and towns.

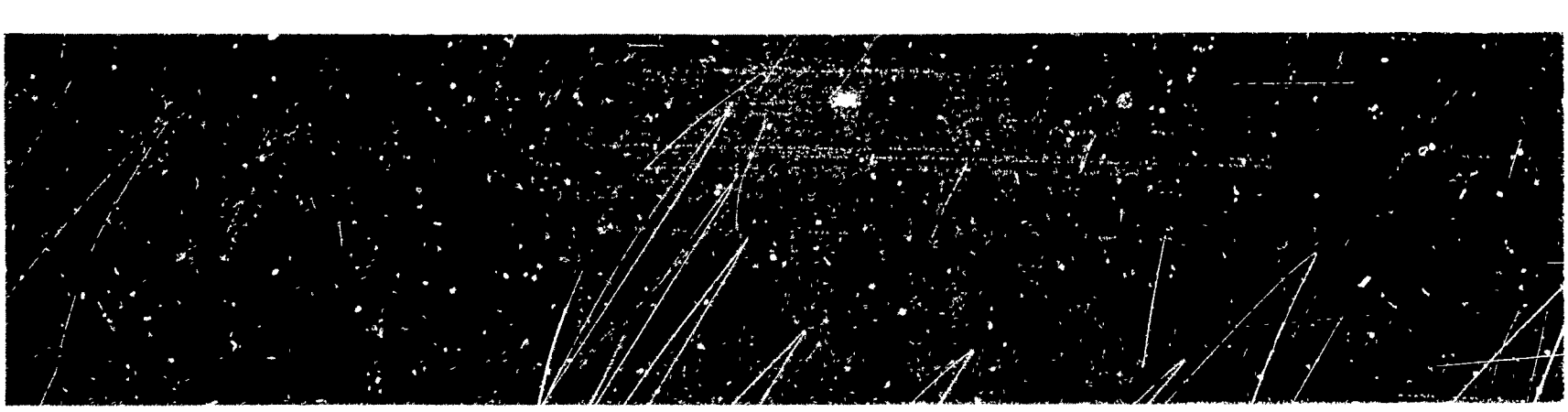
Heywood Memorial Hospital in Gardner contracts rehabilitation services with the Easter Seal Society for a full time physical and occupational therapy staff and a part time speech therapist and social service staff. Rutland Heights Hospital, a chronic disease hospital, (Massachusetts Department of Public Health) provides extensive medical and vocational rehabilitation services through a combination rehabilitation and physical medicine unit, a physical therapy and occupational therapy unit and a social service unit. In addition, this hospital provides vocational evaluation, vocational counseling, prevocational training and job placement.

Gardner Visiting Nurse Association contracts for the services of a physical therapist. Westminster Board of Health provides limited physical therapy services. The private Devereux School in Rutland provides vocationally oriented programs to its adolescent patients. In collaboration with the Massachusetts Department of Public Health, arrangements have been made by the Massachusetts Department of Mental Health to use a portion of Rutland Heights Hospital for the Rutland Heights Mental Health Rehabilitation Center, providing comprehensive rehabilitation services to adolescent retardates.

School systems of Athol, Phillipston, Royalston, Templeton and Winchendon offer a number of vocational training programs beginning at the high school level for retarded students. Athol and Winchendon systems also provide prevocational training at the elementary school level.

The Greater Gardner Association for Retarded Children Workshop serves a very small number of clients in a limited arts and crafts program. The Gardner-Athol Area Mental Health Association has established a workshop for mental patients at Gardner State Hospital.

Massachusetts Rehabilitation Commission offices at Greenfield and Worcester cover the area, as do the Gardner, Athol, Ware and Worcester offices of the Division of Employment Security.



GRAFTON

Cities and Towns

Bellingham, Blackstone, Douglas, Franklin,
Grafton, Hopedale, Medway, Mendon,
Milford, Millbury, Millville, Northbridge,
Sutton, Upton, Uxbridge

Major Rehabilitation Resources

- Grafton Venture Inc., Grafton State Hospital

This area is composed of fifteen communities and is approximately 20 miles southwest of Boston. No general hospitals in the area provide rehabilitation services.

Blackstone Board of Health provides physical therapy services to Millville and Blackstone, while Sutton and Uxbridge Boards of Health have a part time social worker. Physical, occupational and speech therapy are contracted by the Franklin Visiting Nurse Association and the Millbury Society for District Nurses.

Bellingham, Franklin and Grafton schools provide prevocational services to retarded students on a primary grade level. Blackstone and Millville offer prevocational and limited vocational training to ungraded retarded students. Milford offers a variety of prevocational and vocational programs beginning at the junior high level to its retarded and emotionally disturbed students.

The Grafton Venture Inc., workshop at the Grafton State Hospital serves approximately 20 inpatients annually.

The area is served by the Massachusetts Rehabilitation Commission offices in Milford and Worcester and the Division of Employment Security offices in Milford, Worcester, and Webster.

There are no workshop facilities for outpatient disabled citizens in the area, the closest being in Worcester.

HAVERHILL

Cities and Towns

Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Rowley, Salisbury, West Newbury

Major Rehabilitation Resources

None

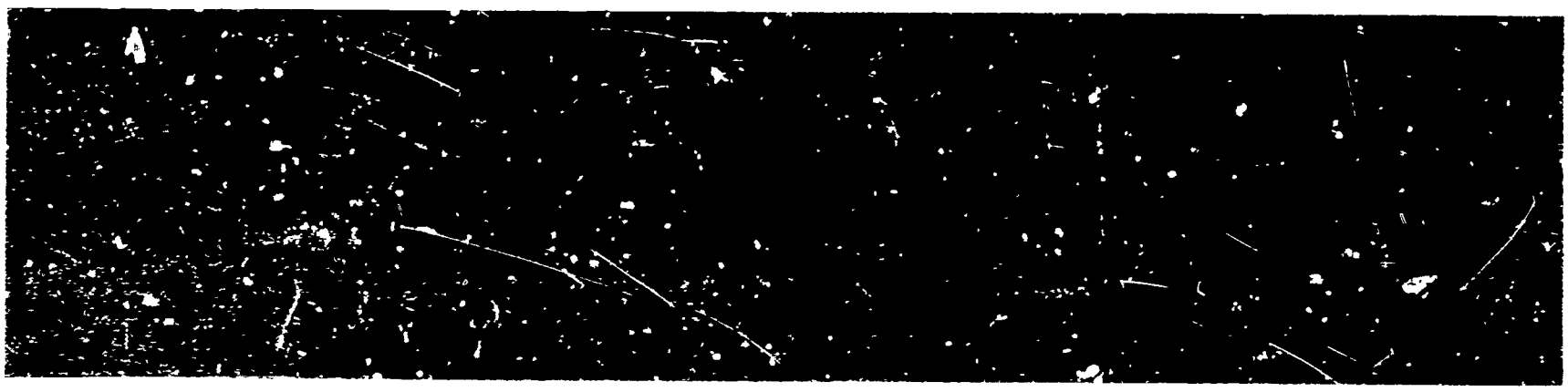
The Haverhill area, composed of 11 cities and towns, is located in the extreme northeastern section of the state, bordering on New Hampshire and the Atlantic Ocean.

None of the four general hospitals in the area provide notable rehabilitation services.

Each of the towns receives physical therapy services through various boards of health, with the exception of Boxford which receives speech therapy through an arrangement with the Topsfield Community Club. Welfare departments in the area offer referral service only, except Newburyport, which does have its own evaluation services available to welfare applicants.

At the high school level, the Haverhill school system offers vocational training to retarded individuals. Two other towns, Rowley and Georgetown, make arrangements with Ipswich and Haverhill respectively, for vocational education of their physically, mentally, and emotionally handicapped students.

No workshops are located in this area, with the closest facilities being in Lawrence, Lowell and Salem. The Massachusetts Rehabilitation Commission's offices in Lowell and Lynn service this area. The Division of Employment Security offices in Haverhill and Newburyport, both within the area, are responsible for the 11 communities.



HOLYOKE

Cities and Towns

Belchertown, Chicopee, Easthampton, Granby, Holyoke, Ludlow, South Hadley, South Hampton

Major Rehabilitation Resources

- Holyoke-Chicopee-Northampton Area Mental Health Center, Holyoke
- Holyoke Hospital
- Providence Hospital, Holyoke

This predominantly rural area just north of Springfield in the western part of the state includes the industrial communities of Chicopee and Holyoke.

Providence Hospital in Holyoke has physical therapy and social service departments. Holyoke Hospital has limited physical therapy service.

Health agencies furnish a variety of physical rehabilitation services to the six centrally located communities in the area, while Southampton and Belchertown have no such services. Physical therapy and homemaker programs are available to the Visiting Nurse Association in Holyoke through a large part time staff of home health aides. The Holyoke-Chicopee-Northampton Area Mental Health Center in Holyoke provides vocational rehabilitation services in the form of vocational counseling and referral to its clients when needed.

Holyoke Family Service Society is the only generic social and family service agency offering counseling and referral services in the area. However, no specific vocationally oriented programs are provided.

Holyoke is also the only community providing vocational education programs to both physically handicapped and retarded children. Chicopee and Ludlow offer limited programs to their retarded students and the remaining five towns have arrangements with the others to educate their handicapped.

There are no workshops or rehabilitation centers in the area, with the closest facilities being in Springfield. The area is also served by the Springfield district office of the Massachusetts Rehabilitation Commission. The Division of Employment Security offices are located outside the area in Ware, Springfield, Northampton and within the area in Chicopee and Holyoke.

LAWRENCE

Cities and Towns

Andover, Lawrence, Methuen, North Andover

Major Rehabilitation Resources

- Bon Secours Hospital, Methuen
- Greater Lawrence Association for Retarded Children Workshop, Burke Memorial Hospital, Lawrence
- Greater Lawrence Guidance Center
- Lawrence General Hospital Alcoholism Clinic
- United Cerebral Palsy Association of the Merrimack Valley Area, Inc., at Burke Memorial Hospital, Lawrence

The Lawrence area is located north of Boston on the New Hampshire border.

Lawrence General Hospital has a physical medicine department with extensive physical therapy and speech therapy services, and a small social service department. Bon Secours Hospital in Methuen also has a physical medicine department providing extensive occupational and physical therapy services and a limited social service department.

Visiting nurse associations in the area provide physical therapy and home health aides. Among mental health facilities, the Alcoholism Clinic at the Lawrence General Hospital provides job placement and followup services to a small number of their clients, while a larger number are referred to the Division of Employment Security. Greater Lawrence Guidance Center offices offer vocational counseling to clients through a volunteer tutor.

Lawrence Welfare Department does vocational evaluations of many of its candidates. Jewish Family Service of Lawrence provides limited vocational counseling to clients under 21 years of age.

Vocational rehabilitation services in the Lawrence and Andover school systems are limited to prevocational and vocational training, respectively, for retarded children. North Andover arranges with the above systems and with the John T. Berry Rehabilitation Center in North Reading for services to its handicapped children.

The only special disability facility in the area is the United Cerebral Palsy Association of the Merrimac Valley Area, Inc., at Burke Memorial Hospital in Lawrence. It provides approximately 120 patients annually with medical rehabilitation, prevocational evaluation, occupational and physical therapy, and speech testing and therapy. Also located at the Burke Memorial Hospital is the only workshop in the area, the Greater Lawrence Association of Retarded Children Workshop. This facility provides 20 clients with an arts and crafts program but has no formal vocational rehabilitation program.

All four communities in the area are served by both Massachusetts Rehabilitation Commission and Division of Employment Security offices located outside the area in Lowell.

LOWELL

Cities and Towns

Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsborough, Westford, Wilmington

Major Rehabilitation Resources

- Lowell Association Workshop for the Blind
- Lowell General Hospital
- H.C. Solomon Mental Health Center, Lowell
- Merrimack Valley Goodwill Industries Workshop, Lowell
- Merrimack Valley Workshop, Lowell
- Renaissance Club, Lowell
- St. John's Hospital, Lowell
- St. Joseph's Hospital, Lowell
- Tewksbury Hospital
- Veterans Administration Mental Hygiene Unit, Lowell

The nine communities comprising the Lowell area are located in the northeastern section of the state.

St. Joseph's Hospital in Lowell provides a rehabilitation unit with occupational and physical therapy and social services. Limited rehabilitation services are provided in physical therapy and social service departments at the Lowell General Hospital and at St. John's Hospital in Lowell. Tewksbury Hospital, under the auspices of the Department of Public Health, offers physical therapy and social services for chronically disabled patients.

Homemaker services and physical therapy are provided to the communities of Lowell, Dracut, Tewksbury, Chelmsford and Westford by the Lowell Visiting Nurse Association. Rehabilitation services, including a full time vocational rehabilitation counselor, are available at the H.C. Solomon Mental Health Center in Lowell, where efforts are being made to develop a comprehensive rehabilitation program for mental patients. Also providing similar services are the Veterans Administration Mental Hygiene Unit in Lowell. In addition, the Renaissance Club, in Lowell, is a voluntary social club providing vocational counseling and evening social activities to former mental patients.

The only school system providing any vocational training for its handicapped students is Wilmington, while Chelmsford and Tewksbury arrange for special education with other systems.

Lowell Association Workshop for the Blind serves up to 150 clients annually. The Merrimack Valley Goodwill Industries Workshop provides up to 85 clients of many different types of disabilities per year with extensive vocational services. Vocational adjustment and extended employment services are furnished at the Merrimack Valley Workshop for retarded persons in Lowell to up to 35 clients annually.

This area is served by the Massachusetts Rehabilitation Commission and Division of Employment Security offices located in Lowell.

LYNN

Cities and Towns

Lynn, Lynnfield, Nahant,
Saugus Swampscott

Major Rehabilitation Resources

- Lynn Goodwill Industries, Morgan Memorial Inc.
- Lynn Hospital
- Saugus General Hospital
- Union Hospital, Lynn
- Work Training Program, Lynn Welfare Department

On the north shore of Massachusetts, the Lynn area is composed of five communities with the city of Lynn as the population center.

Lynn Hospital has relatively comprehensive services through its physical medicine department. Union Hospital of Lynn has limited social service and physical therapy departments for both inpatients and outpatients. Saugus General Hospital also provides physical therapy services.

Visiting Nurse Association of Greater Lynn, Inc., offers limited physical therapy services, bedside care, and referral services. Homemaker Service of Greater Lynn, Inc., located in Swampscott, assists the incapacitated homemaker in home management.

Lynn Welfare Department sponsored limited vocational rehabilitation programs through its Work Training Program under Title V of the Economic Opportunity Act.

Only the Saugus and Lynn school systems provide vocational training for their handicapped students. At the junior high level, Lynn offers occupational training and Saugus offers a variety of prevocational and vocational programs.

The only special rehabilitation facility on the north shore is the multidisability workshop in Lynn, Morgan Memorial, Inc. In its present program the workshop employs approximately 70 persons and offers vocational evaluation, prevocational and vocational training, job analysis, on-the-job training and transitional and extended employment.

The area is served by the Massachusetts Rehabilitation Commission and the Division of Employment Security offices in Lynn.

MALDEN

Cities and Towns

Everett, Malden, Medford

Major Rehabilitation Resources

- Malden Action, Inc.
- Malden Hospital
- Widden Memorial Hospital, Everett
- Lawrence Memorial Hospital, Medford

The Malden area, located north of Boston, is comprised of three industrial cities within commuting distance of the state Capitol.

Limited rehabilitation services are provided in the area's three general hospitals. Malden Hospital provides physical therapy to inpatients and social services to outpatients. Whidden Memorial Hospital in Everett and the Lawrence General Hospital in Medford both have limited physical therapy programs.

Malden Action, Inc., provides a relatively complete range of vocational services under Title V of the Economic Opportunity Act to welfare applicants. The Malden branch of the Family Service Association of Greater Boston only provides referral services.

The Everett school system arranges to send retarded students to the John T. Berry Rehabilitation Center in North Reading and to the Fernald State School Community Evaluation and Rehabilitation Center in Waltham.

The closest special rehabilitation facilities outside of Boston are the multidisability workshop in Lynn, the single disability workshop in Woburn, and the single extended employment workshop for the blind in Cambridge, with none available in the area itself.

Division of Employment Security offices are located within the area in Malden and Medford. The Massachusetts Rehabilitation Commission offices are located outside the area in Somerville and in Government Center.

MEDFIELD

Cities and Towns

Canton, Dedham, Medfield, Needham, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, Wrentham

Major Rehabilitation Resources

- Charles River Workshop, Needham
- Glover Memorial Hospital, Needham
- Leslie B. Cutler Clinic, Norwood
- Massachusetts Hospital School for Crippled Children, Canton
- Medfield State Hospital, Norfolk Sheltered Workshop
- Norwood Hospital
- Wrentham State Hospital, Wrentham Industries Workshop

Located twenty miles southwest of Boston, this essentially suburban area is within commuting distance from Boston.

Norwood Hospital has a recently developed physical medicine department and also offers physical therapy services to other communities in the area. Glover Memorial Hospital in Needham offers limited physical therapy and social work services. Massachusetts Hospital School in Canton offers limited physical therapy and social work services, providing extensive rehabilitation services for children suffering from chronic orthopedic disabilities, with special attention given to high school students in its vocational rehabilitation program. Under the auspices of the Department of Public Health, Pondville Hospital in Norfolk, treating neoplasms and related conditions, has a social service unit only. The hospital at the Correctional Institution in Norfolk also provides limited evaluative and referral services to both inpatients and outpatients.

Medfield State Hospital offers a program for mental patients working in hospital industries and provides comprehensive vocational rehabilitation services. Leslie B. Cutler Clinic, supported and operated jointly by the Massachusetts Department of Mental Health and Norfolk Mental Health Association, provides vocational testing to selected adolescents.

In the area school systems, only Dedham offers prevocational high school level programs to its retarded students while Wrentham offers vocational high school services for handicapped students.

Norfolk Sheltered Workshop at Medfield State Hospital, sponsored by the Norfolk Mental Health Association, provide extensive vocational rehabilitation services to 106 inpatients a year. Vocational rehabilitation counseling, training, and extended employment is also provided to about 40 persons annually by the Wrentham Industrial Workshop at the Wrentham State School for retarded persons. Charles River Workshop, operated by the Charles River Association for Retarded Children, Inc., in Needham, offers vocational rehabilitation services to approximately 30 retarded persons and is the only outpatient workshop facility in the area.

Massachusetts Rehabilitation Commission offices in Brockton and Quincy serve the area. Division of Employment Security offices in Attleboro, Newton, and particularly in Norwood, also serve the area.

MYSTIC VALLEY

Cities and Towns

Arlington, Burlington, Lexington, Winchester, Woburn

Major Rehabilitation Resources

- Charles Choate Memorial Hospital, Woburn
- East Middlesex Association for Retarded Children, Inc., Woburn
- Symmes Hospital, Arlington

Approximately 10 miles northwest of Boston, the Mystic Valley area is comprised of five cities and towns.

Physical therapy services are offered at the Symmes Hospital in Arlington and the Charles Choate Memorial Hospital in Woburn.

Inservice training for staff in job evaluations and placement of clients is made available by the Lexington Welfare Department.

Homebound clients in all the communities except for Woburn can receive physical therapy services from local nursing associations. The Winchester Visiting Nurse Association alone provides social services.

Only the Woburn school system offers a variety of prevocational and vocational programs, beginning in the 7th grade, while the Lexington system provides prevocational training at the ninth grade. Arrangements are made by Burlington to provide for the educational needs of its handicapped students through referral.

Vocational evaluation, training and transitional employment are provided at the East Middlesex Association for Retarded Children, Inc., in Woburn for 35 clients per year.

The Division of Employment Security has an office within the area at Woburn, and others in Waltham and Cambridge. Massachusetts Rehabilitation Commission offices are both located outside the area in Lowell and Somerville.

NEW BEDFORD

Cities and Towns

Acushnet, Dartmouth, Fairhaven, Marion, Mattapoisett, New Bedford, Rochester, Gosnold

Major Rehabilitation Resources

- Cerebral Palsy Clinic of New Bedford
- Homemaker Service of Greater New Bedford
- Opportunity Center of Greater New Bedford
- St. Luke's Hospital, New Bedford, Adult and Child Guidance Clinic, Alcoholism Clinic

This coastal area in southeastern Massachusetts is comprised of eight communities with the city of New Bedford being the population center. The area includes the Gosnold Islands across Buzzards Bay.

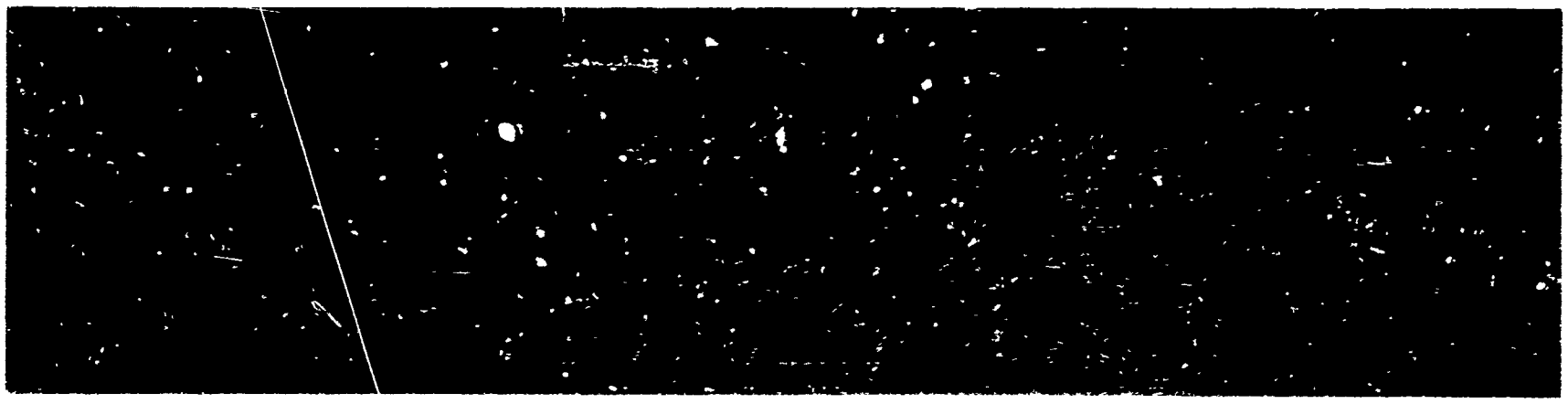
St. Luke's Hospital, New Bedford, provides rehabilitation services in physical therapy, speech and hearing, and social services to both inpatients and outpatients and also has a unique program for rehabilitating stroke patients, serving about 100 patients a year.

Homemaker Service of Greater New Bedford provides homemaker services to three communities. Mental Health facilities within the area do not provide vocational rehabilitation services, with the exception of limited evaluation at the Adult and Child Guidance Clinic and the Alcoholism Clinic of St. Luke's Hospital.

New Bedford school system offers no specialized services for its handicapped students, nor does it make arrangements with any other system for such services. Dartmouth and Fairhaven offer occupational training programs at present for retarded persons.

Cerebral Palsy Council of Greater New Bedford maintains a cerebral palsy clinic which provides day care to approximately 65 clients in the form of medical rehabilitation, evaluation, physical therapy, speech evaluation, and recreational programs. A workshop for retarded and cerebral palsied persons, the Opportunity Center of Greater New Bedford, serving approximately 30 clients annually, provides the only predominately vocational rehabilitation program for the area, including vocational evaluation, personal adjustment training, and transitional and extended employment.

The eight communities within the area are served by the Division of Employment Security office at New Bedford. The Massachusetts Rehabilitation Commission subdistrict office in New Bedford serves the area with the exception of the islands of Gosnold, which are served by the Massachusetts Rehabilitation Commission office in Hyannis.



NEWTON

Cities and Towns

Newton, Wellesley, Weston

Major Rehabilitation Resources

- Catholic Guild for All the Blind, Newton
- Newton-Wellesley Hospital

The Newton area is comprised of three highly affluent suburban communities just west of Boston, all of which are served by several transportation systems connecting the area to Boston.

Newton-Wellesley Hospital, the only general hospital in the area, limits its rehabilitation services to physical therapy, social services and psychiatric care.

Among other health services, the Visiting Nurse Associations of Newton and Weston provides physical therapy to homebound clients and offer referral services. Homemaker Home Health Center in the area provides some health services to physically and mentally disabled homebound clients.

Vocational services in the school system are offered only in Newton and these only to mentally retarded children, beginning with prevocational programs during the elementary years.

A specific disability facility in the area is the Catholic Guild for All the Blind in Newton providing comprehensive rehabilitation services of international repute. No workshops are located in the area, the closest being in Needham at the Charles River Workshop for the retarded.

The Massachusetts Rehabilitation Commission District office in Somerville covers the area as do the Division of Employment Security offices in Newton and Waltham.

PLYMOUTH

Cities and Towns

Bridgewater, Carver, Duxbury, Halifax, Hanover, Hanson, Kingston, Marshfield, Norwell, Pembroke, Plymouth, Plympton

Major Rehabilitation Resources

- Jordan Hospital, Plymouth
- Plymouth County Hospital, Hanover
- St. Coletta's School and Training Center, Hanover

This area, located on the south shore of Boston, is comprised of 12 rural communities.

Jordan Hospital in Plymouth has a contractural agreement with the Easter Seal Society for a part time traveling rehabilitation team, with physical and occupational therapy, social service, rehabilitation nursing and speech therapy services. Plymouth County Hospital in Hanover provides physical and occupational therapy as well as social services.

Carver and Plymouth are under contract for home rehabilitation services from the Easter Seal Society on an on call basis, through their Community Nursing Association and Board of Health, respectively.

Halifax Welfare Department has a vocational expert working on a consultant basis and a program for the vocational evaluation of applicants.

Duxbury school system offers a limited program for training disabled children and also makes arrangements for similar educational programs with the Plymouth school system. The Hanover school system provides a variety of services to its retarded students. Marshfield and Plymouth school systems have prevocational and vocational programs for retarded students at the high school level.

The one major rehabilitation facility in the area is St. Colletta's School, Inc., and Training Center in Hanover, providing 250 educable mentally retarded students per year with personal adjustment training, vocational evaluation, counseling and training and job placement.

The Massachusetts Rehabilitation Commission offices in Quincy and Brockton serve the area. The area is also served by the Plymouth, New Bedford, Brockton and Quincy offices of the Division of Employment Security.

QUINCY

Cities and Towns

Braintree, Cohasset, Hingham, Hull, Milton, Quincy, Randolph, Scituate, Weymouth

Major Rehabilitation Resources

- Boston School for the Deaf, Randolph
- Cerebral Palsy Treatment Center, Quincy
- Norfolk County Hospital, Braintree
- Occupational Training Center, Quincy
- Quincy City Hospital

This area, located on the south shore, is comprised of nine communities with industrialized Quincy as its largest city.

Quincy City Hospital provides some rehabilitation services through physical therapy and social service departments. In Braintree, the Norfolk County Hospital offers inpatients with respiratory disabilities occupational therapy and social services.

Physical therapy is provided by every community to its homebound clients, either through visiting nurse associations or boards of health.

While both Randolph and Weymouth Welfare Departments have programs for inservice training of staff in job placement and evaluation, Weymouth alone has a program for the vocational evaluation of welfare applicants and Randolph has available the consulting services of a vocational rehabilitation expert. The only social and family service agency to furnish vocational rehabilitation services is the Family Service Association of Quincy, providing job placement and followup services.

All community school systems except Weymouth provide a variety of prevocational and vocational programs for retarded children at the junior high level. Weymouth has the largest number of handicapped students but offers no vocational education programs.

Two special disability facilities are located in the area, one for the cerebral palsied and the other for deaf persons. In Quincy, the Cerebral Palsy Treatment Center, maintained by United Cerebral Palsy Association of the South Shore, Inc., services 45 communities in southern Massachusetts with physical and occupational therapy, social services, speech evaluation and therapy, counseling, personal adjustment training and a psychiatric consultant. The Boston School for the Deaf in Randolph serves deaf and deafaphasic students with various speech and hearing evaluation, therapy and prevocational training. The only workshop in the area is the Occupational Training Center in Quincy serving 22 mentally retarded or emotionally disturbed clients daily with a full range of vocational rehabilitation services.

All communities, except Randolph, are served by the Massachusetts Rehabilitation Commission and the Division of Employment Security offices in Quincy.

READING

Cities and Towns

Melrose, North Reading, Reading, Stoneham, Wakefield

Major Rehabilitation Resources

- Melrose-Wakefield Hospital, Melrose
- New England Memorial Hospital, Stoneham
- John T. Berry Rehabilitation Center, North Reading

The Reading area, located north of Boston, is comprised of five suburban communities. Rapid transit from Boston will be extended into this area in the near future.

Melrose-Wakefield Hospital provides physical therapy services. New England Memorial Hospital in Stoneham has physical and occupational therapy, and social service units.

Physical therapy is the only rehabilitation service provided in the area by the combined Visiting Nurse Association in Reading and the local Visiting Nurse Association in Melrose.

Eastern Middlesex Guidance Center in North Reading provides comprehensive vocational services to a small number of their clients.

All communities except for Wakefield provide at least one type of prevocational training in their school systems. Reading and Stoneham send several retarded students to the John T. Berry Rehabilitation Center, North Reading. This center, under the auspices of the Massachusetts Department of Mental Health, is the only rehabilitation facility in the area. It serves mildly and moderately retarded persons with residential and day programs, providing medical, psychological, and vocational rehabilitation annually to 200 clients over the age of sixteen.

The area is served by the Massachusetts Rehabilitation Commission district office in Lowell and the Division of Employment Security offices in Woburn and Malden, all situated outside the area.

SOUTHBRIDGE

Cities and Towns

Brimfield, Brookfield, Charlton, Dudley, East Brookfield, Holland, Monson, North Brookfield, Oxford, Palmer, Southbridge, Spencer, Sturbridge, Wales, Ware, Warren, Webster, West Brookfield

Major Rehabilitation Resources

- Mary Lane Hospital, Ware
- Harrington Memorial Hospital, Southbridge
- Monson State Hospital, Palmer

The Southbridge area is made up of 18 communities located in the south-central part of Massachusetts. The area is equidistant between Springfield and Worcester.

Mary Lane Hospital in Ware has part time physical therapy and social service departments with limited facilities. Harrington Memorial Hospital in Southbridge also has part time physical and occupational therapy and social services.

A complete range of rehabilitation nursing services are provided on a part time basis by the Visiting Nurse Association of Ware. Charlton Public Health Nurse Association and the Sturbridge Visiting Nurse Association contract physical rehabilitation services from the Easter Seal Society. The towns of Spencer, Palmer, Monson and Webster all have some physical therapy services provided on either a part time or on-call basis by local samaritan and nursing associations.

North Brookfield is the only school system which offers vocational training to retarded students at the junior high level. Monson and North Brookfield make arrangements with other school systems outside the area for the vocational education of their handicapped students.

The only facility serving a specific disability in the area is the Monson State Hospital in Palmer, offering both inpatient and outpatient rehabilitation programs to 1600 epileptic and retarded persons, including work adjustment groups and vocational counseling and placement at nursing jobs within the hospital.

This area is totally served by Massachusetts Rehabilitation Commission offices outside the area in Springfield and Worcester. However, Division of Employment Security offices in Ware and Webster are found within this area.

There are no outpatient workshop facilities in the area.

SPRINGFIELD

Cities and Towns

East Longmeadow, Hampden, Longmeadow, Springfield, Wilbraham

Major Rehabilitation Resources

- Alcoholism Clinic, Springfield Municipal Hospital
- Jewish Social Service Bureau, Springfield
- Mercy Hospital, Springfield
- Rehabilitation Department, Springfield Hospital
- Shriners Hospital for Crippled Children, Springfield
- Springfield Day Nursery Corporation
- Springfield Goodwill Industries, Inc.
- Springfield Municipal Hospital
- Springfield Salvation Army
- Springfield Workshop for the Blind
- Wesson Memorial Hospital, Springfield

The Springfield area includes the city of Springfield, the third largest city in Massachusetts, and four additional small towns, both suburban and rural.

Extensive rehabilitation services are offered at three large general hospitals in the area. The Rehabilitation Department of the Springfield Hospital provides physical, occupational and speech therapy and speech and hearing evaluation. Mercy and Wesson Memorial Hospitals both have physical therapy and social service facilities. Limited rehabilitation services are provided at the Springfield Municipal Hospital, while the Shriners Hospital for Crippled Children provides physical therapy services.

Visiting Nurse Association office in Springfield offers physical therapy as its only rehabilitative service to the area. Our Lady of Lourdes School in Springfield, in addition to providing basic psychiatric care, also furnishes vocational programs to deliquent and emotionally disturbed girls. The Alcoholism Clinic at the Springfield Municipal Hospital also provides rehabilitation service to clients.

Jewish Social Service Bureau of Springfield offers sheltered workshop experience, vocational counseling and referral services, primarily to senior citizens, and operates a summer employment program for teenagers.

All community school systems except Hampden provide prevocational programs for the retarded. Hampden and East Longmeadow are the only two towns in the area which do not offer vocational training.

Springfield Day Nursery Corporation, a Red Feather Agency, provides a group educational program for physically handicapped children aged three through six. Two workshops and one rehabilitation facility are also in the area. Springfield Goodwill Industries, Inc., a major multidisability workshop with extensive services, provides approximately 130 clients with evaluation and training and 237 persons with transitional and extended employment annually. Springfield Workshop for the Blind, a state owned extended employment program, serves 20 male clients with subcontract work. Springfield Salvation Army serves Franklin, Hampshire, Westfield, Holyoke, Chicopee and Springfield areas with occupational therapy, vocational training, on-the-job training, recreational programs and counseling for transient and alcoholic persons, handling up to 60 clients.

Massachusetts Rehabilitation Commission and Division of Employment Security offices are located in Springfield.

TAUNTON

[redacted]

Berkley, Dighton, Lakeville, Middleboro, Raynham, Rehoboth, Seekonk, Taunton

[redacted]

- Dever State School, Taunton, PREP Workshop
- Lakeville Hospital, Middleboro, Cerebral Palsy Unit
- Morton Hospital, Taunton

The Taunton area is made up of eight rural cities and towns located south of Boston, bordering on the eastern Rhode Island state line.

Morton Hospital in Taunton offers some rehabilitation service programs with occupational therapy, physical therapy, social services, and speech evaluation and therapy contracted through the Easter Seal Society. Lakeville Hospital, under the auspice of the Massachusetts Department of Public Health, has physical and occupational therapy and social service departments, serving persons with primarily orthopedic problems

Taunton Visiting Nurse Association provides homemaker services to Taunton, Raynham, Rehoboth and Berkley.

Taunton State Hospital provides vocational counseling and referral services in addition to job placement and followup services to its mental patients, while the Dever State School has a sheltered workshop for its inpatient population.

One special disability facility is located in the area, the Lakeville Hospital Cerebral Palsy Unit in Marlboro, which offers physical, occupational and referral services.

Vocational training for handicapped children is limited to grade school level prevocational training programs in Seekonk for the retarded and in Lakeville for physically handicapped, retarded and emotionally disturbed children.

The area is served by the Brockton Massachusetts Rehabilitation Commission office and the Taunton Division of Employment Security office.

WALTHAM

Cities and Towns

Belmont, Waltham, Watertown

Major Rehabilitation Resources

- McLean Hospital, Belmont — Day Care Unit
- Metropolitan State Hospital, Sheltered Workshop, Waltham
- Middlesex County Sanatorium, Waltham
- Perkins School for the Blind, Watertown
- Waltham Court Clinic
- Waltham Hospital

The three communities making up the Waltham area are located just northwest of Boston.

Waltham Hospital provides physical therapy services in a Physical Medicine Department and also has a social service unit. Under the auspices of the Department of Public Health, the Middlesex County Sanatorium in Waltham serves pulmonary tubercular patients with recreational and occupational therapy and social services. In Belmont, the McLean Hospital provides extensive rehabilitation services in occupational and physical therapy and social service departments to its private mental patients.

Visiting nurse associations in each town offer physical therapy on a part time professional basis to homebound clients. The Belmont Board of Health has the services of a vocational rehabilitation specialist available on a part time basis.

Comprehensive vocational rehabilitation services are provided to a limited number of patients at the Day Care Unit of the McLean Hospital. More than half of all patients, including adolescents, receive vocational counseling from a rehabilitation counselor affiliated with the hospital. Sheltered work experience is made available at the Metropolitan State Hospital in Waltham under the auspices of the Brookline Mental Health Association to chronically ill mental patients. The Waltham Court Clinic offers vocational counseling to a number of its clients.

While the welfare departments of all communities have programs for referring clients to official rehabilitation agencies, only the Watertown Welfare Department provides vocational evaluation to welfare applicants. Family Counseling, Inc., in Waltham provides limited vocational rehabilitation services to a small number of clients.

Waltham and Belmont school systems provide prevocational and vocational programs for their handicapped students. Comprehensive social and educational rehabilitation services to the blind are provided at the world renowned Perkins School for the Blind in Watertown.

The area is served by the Massachusetts Rehabilitation Commission Somerville office. Division of Employment Security offices in Waltham, Cambridge and Newton also serve the area.

WESTBOROUGH

Cities and Towns

Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Millis, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, Westborough

Major Rehabilitation Resources

- Cushing Hospital, Framingham
- Framingham Correctional Institute
- Framingham Court Clinic
- Framingham Union Hospital
- Leonard Morse Hospital, Natick

The Westborough area, west of Boston, is made up of 15 residential communities, equally accessible to Worcester and the Capitol.

Four hospitals are located in the area, all providing some rehabilitation services. Framingham Union Hospital provides limited physical therapy and social services to its patients. In Natick, the Leonard Morse Hospital has a limited physical medicine department specializing in physical therapy facilities. Marlborough Hospital provides limited physical therapy services while Cushing Hospital in Framingham provides comprehensive rehabilitation services for a specialized group: the aged — 65 years and over.

Millis and Holliston provide part time speech therapy services and have physical therapy services available to homebound clients either on a contractual basis from the Framingham Visiting Nurse Association or from their local health agency. Framingham Correctional Institute offers vocational counseling to its inmates and the parole office of the Framingham Court Clinic provides job placement services. Trinity Mental Health Association, Inc., in Framingham, provides limited vocational testing, placement and followup services to a small percentage of clients.

Hudson and Millis Welfare Departments furnish vocational evaluation to applicants.

The Hudson school system offers prevocational training to retarded children while Ashland and Wayland provide a number of vocational training programs on the high school level, also to the retarded. Framingham and Natick have a variety of both prevocational and vocational training for their retarded children at the junior high and high school level.

These communities are served locally by a Massachusetts Rehabilitation Commission office, in Natick, and the rest of the area is covered by the Worcester, Milford, Somerville, Lowell and Quincy offices. Division of Employment Security offices are located in Marlborough and Framingham, within the area, and Milford, Waltham and Norwood, which are outside the area.

WESTFIELD

Cities and Towns

Agawam, Blandford, Chester, Granville, Huntington, Montgomery, Russell, Southwick, Tolland, Westfield, West Springfield

Major Rehabilitation Resources

- Noble Hospital, Westfield
- Western Massachusetts Hospital, Westfield

The Westfield area includes 11 communities located in the southwestern part of the state.

By combining services, the Western Massachusetts Hospital of the Department of Public Health and Noble Hospital, both in Westfield, provide physical and occupational therapy and social services.

A nursing service in Chester provides the only such partial rehabilitation service in the area besides the town of West Springfield which receives part time services from the Springfield Visiting Nurse Association. Westfield Area Child Guidance Clinic provides limited vocational testing and consultation for children under 18 years of age.

Huntington, Westfield and West Springfield school systems offer prevocational and vocational training to retarded students. Blandford, Chester, Huntington, Montgomery, Russell, and Westfield make arrangements with the West Springfield and Springfield school systems to provide their retarded students with training. West Springfield High School is developing a unique vocational training program for retarded adolescents.

All area communities are covered by the Massachusetts Rehabilitation Commission and Division of Employment Security Office in Springfield, outside of the area.

There are no workshop facilities presently available; the closest are those in Springfield.

WORCESTER

Cities and Towns

Auburn, Boylston, Holden, Leicester, Paxton, Shrewsbury, West Boylston, Worcester

Major Rehabilitation Resources

- Catholic Charities, Worcester
- Easter Seal Society for Crippled Children and Adults of Massachusetts, Inc., Worcester
- Faith, Inc., Worcester
- Memorial Hospital, Worcester
- Rehabilitation Center of Worcester, Inc.
- St. Vincent Hospital, Worcester
- Salvation Army Men's Social Service Center, Worcester
- Worcester Area Occupational Training Center for the Mentally Retarded
- Worcester City Hospital
- Worcester County Sanatorium, Boylston
- Worcester County Hearing and Speech Center Inc.
- Worcester State Hospital — Night Center
- Worcester Youth Guidance Center

This midstate area is comprised of seven towns and the city of Worcester, the second largest city in the state.

St. Vincent Hospital in Worcester provides rehabilitation services in physical and occupational therapy and social services. A physical medicine department, physical therapy and social service units are offered at the Worcester City Hospital. Memorial Hospital in Worcester, has physical therapy and social services available. Worcester County Sanatorium in Boylston provides social services and occupational therapy to patients with chronic respiratory disabilities. In addition, the Rehabilitation Center of Worcester, Inc., sponsored by the Community Service and Easter Seal Society, provides medical rehabilitation services, including physical, occupational and speech therapy, and prevocational evaluation. A relatively wide array of medical rehabilitation services are available to the area.

Holden and Shrewsbury Boards of Health offer part time physical therapy services to their clients, while the Worcester Visiting Nurse Association provides similar services as well as four full time Home Health Aides. Shrewsbury Board of Health has an occupational therapist available for medical patients. The Worcester Youth Guidance Center furnishes vocational rehabilitation services to selected clients under 21. Job training and placement are available for a small number of youths at the Night Center at Worcester State Hospital. Vocational testing is offered at the Alcoholism Clinic at St. Vincent Hospital.

In the towns of Boylston, Holden, Shrewsbury, West Boylston and Worcester, welfare departments have the potential to provide vocational evaluations of applicants. Catholic Charities in Worcester furnishes vocationally oriented services such as work adjustment groups, sheltered work experience, vocational counseling and job placement. Faith, Inc., provides similar services to alcoholic women.

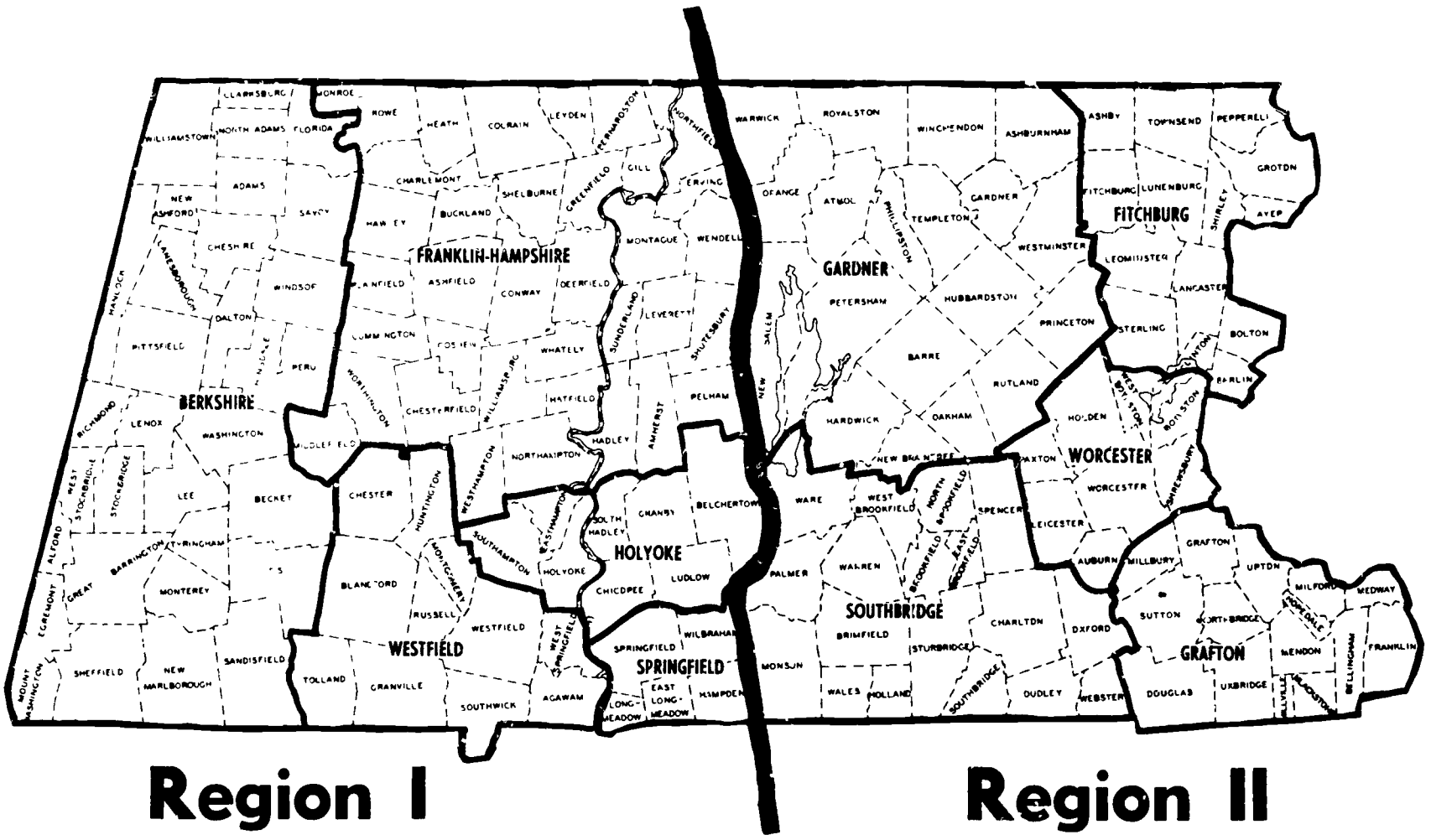
Auburn, Holden, Leicester, Paxton and Worcester school systems provide prevocational training for their retarded students. Vocational training is offered in the Auburn and Worcester systems, while Worcester also offers on-the-job training.

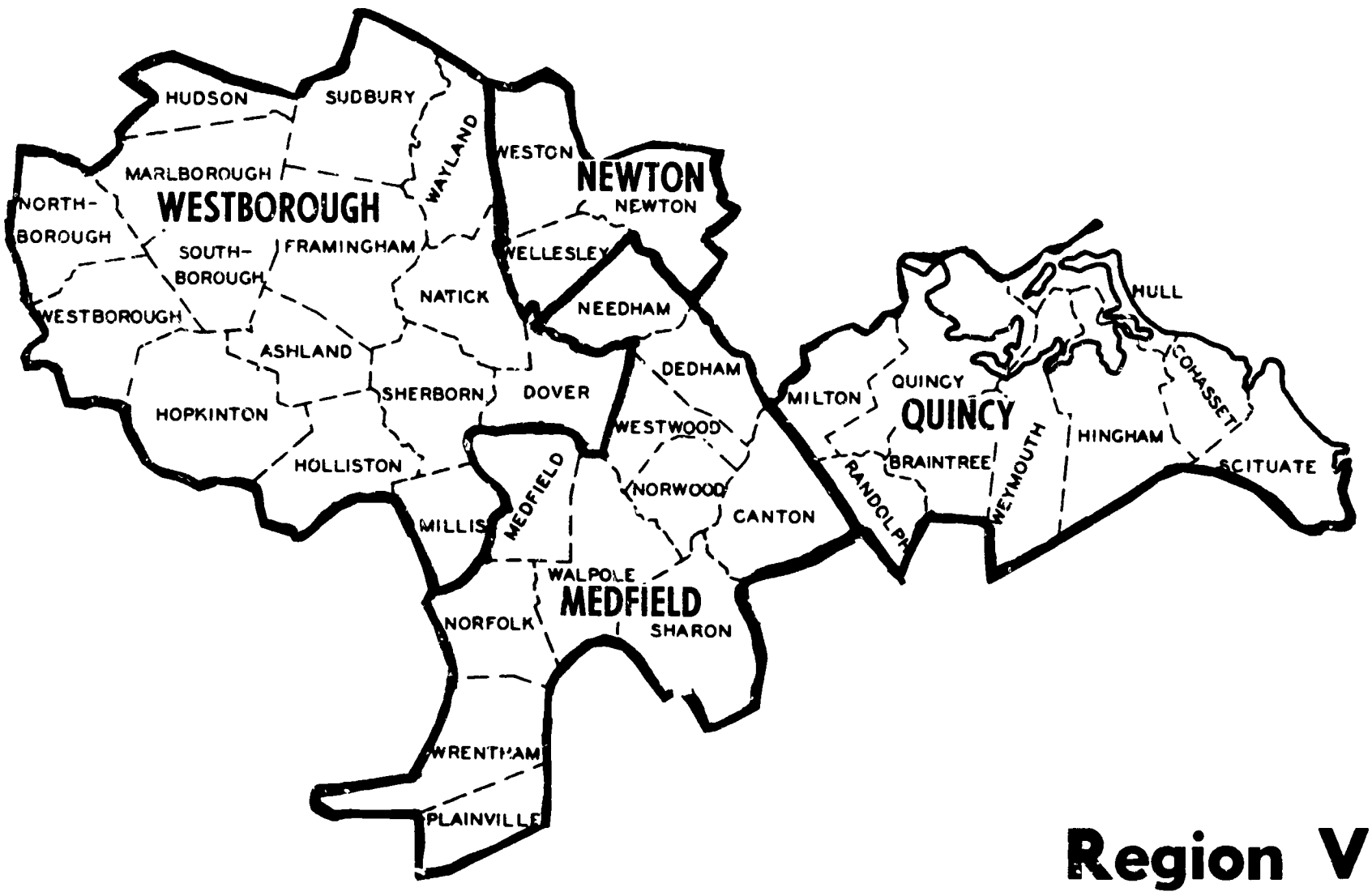
As the only speech and hearing facility in several surrounding areas, the Worcester County Hearing and Speech Center, Inc., provides extensive services including hearing aid testing, vocational testing and counseling, placement and personal adjustment training to approximately 1,900 persons annually. Also in Worcester is the central office of the Easter Seal Society offering medically oriented programs for handicapped persons.

Serving 50 clients annually, the Worcester Area Occupational Training Center for the Mentally Retarded provides vocational evaluation, training, and extended transitional employment. A single disability workshop for the blind in Worcester provides 6 clients per year with extended employment only. Morgan Memorial Goodwill Industries has just started a multidisability workshop in Worcester. Salvation Army Men's Social Service Center provides medical evaluation, occupational therapy, counseling, vocational training, and transitional employment to 450 clients annually.

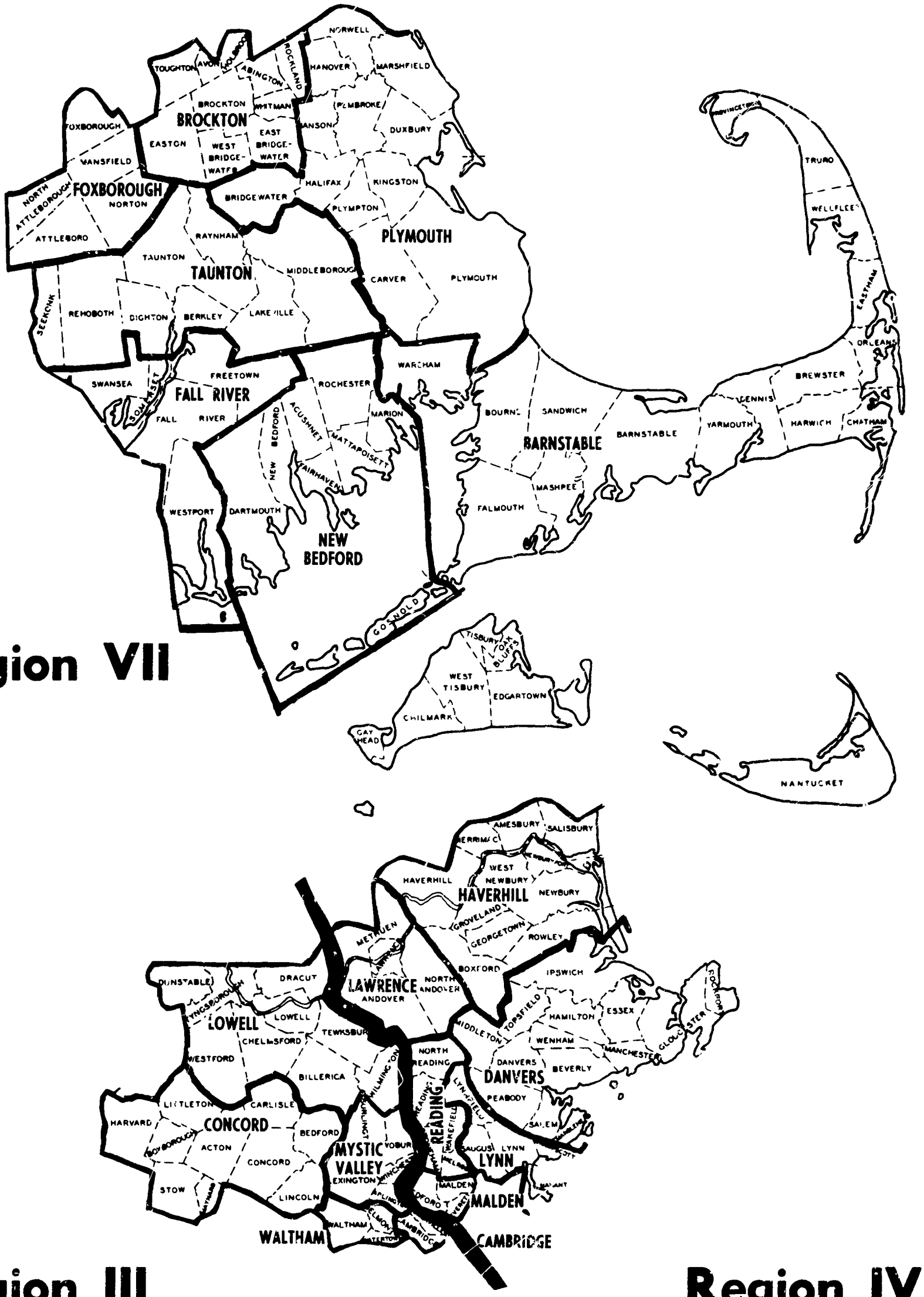
This area is totally covered by the Massachusetts Rehabilitation Commission and the Division of Employment Security offices located in Worcester.

GEOGRAPHIC SERVICE AREAS IN REGIONS I, II AND V





GEOGRAPHIC SERVICE AREAS IN REGIONS III, IV AND VII

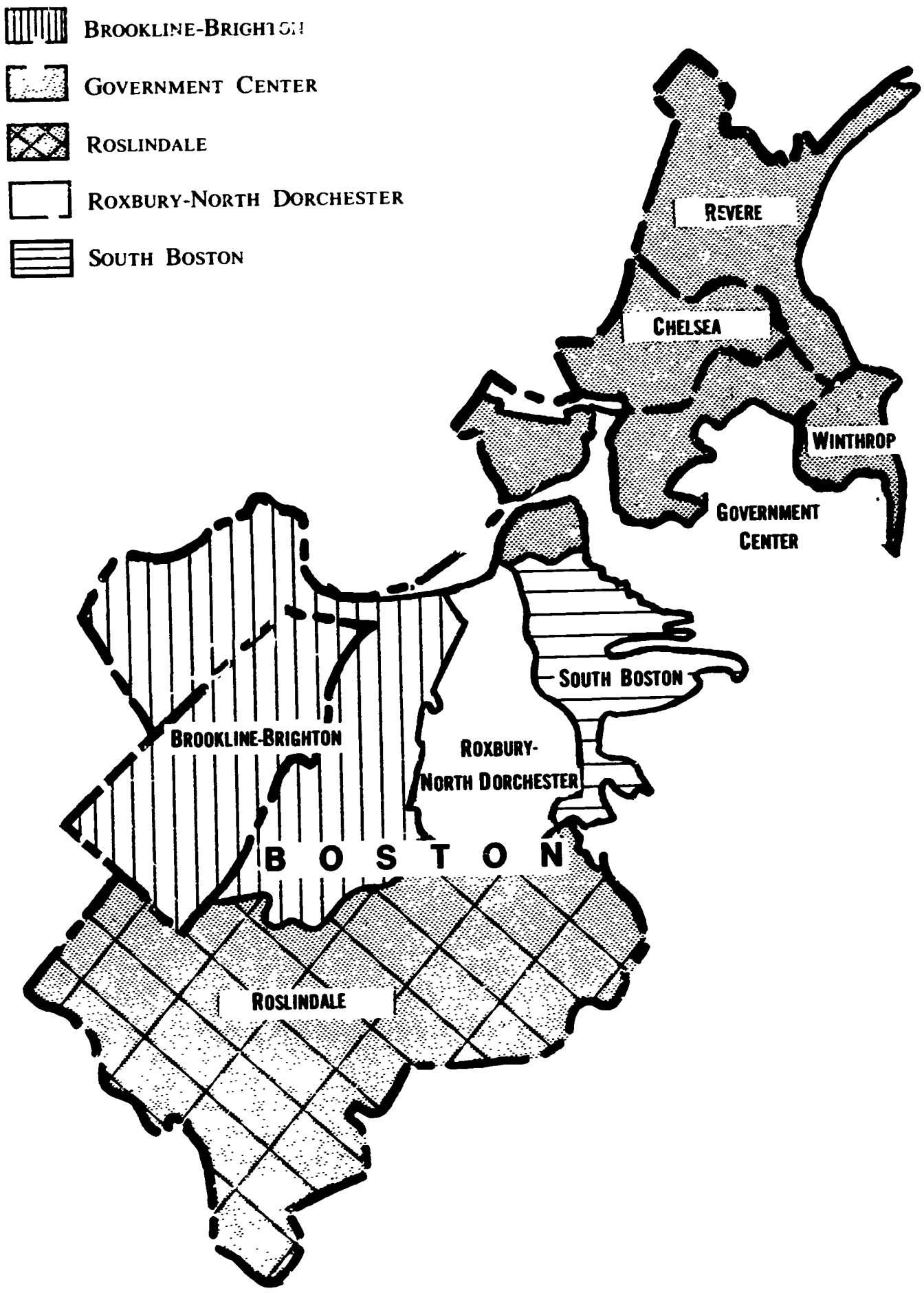


Region VII

Region III

Region IV

GEOGRAPHIC SERVICE AREAS IN REGION VI



THE ADMINISTRATION OF REHABILITATION SERVICES

RECOMMENDATIONS

Reorganization and Decentralization of the Massachusetts Rehabilitation Commission

STATE OFFICE REORGANIZATION

5. The state office of the Massachusetts Rehabilitation Commission should be reorganized to strengthen top level administration and to enable the Commission to carry out its rapidly increasing responsibilities.

PRINCIPAL POSITIONS

6. Principal positions should be the Commissioner, Deputy Commissioner and four Assistant Commissioners for: Planning, Training, Research, and Education; Community Programs; Client Services; and Administration.

REGIONAL REHABILITATION OFFICES

7. Regional rehabilitation offices headed by Regional Rehabilitation Directors should be established to supervise and coordinate the area rehabilitation offices and to provide specialized counselor staff for low prevalence hard to serve disability groups such as the deaf.

AREA REHABILITATION OFFICES

8. Area rehabilitation offices headed by Area Rehabilitation Directors should be established in each of the proposed geographic service areas to provide rehabilitation services for handicapped persons within their areas and to develop comprehensive area rehabilitation programs.

STATE REHABILITATION ADVISORY BOARD

9. A State Rehabilitation Advisory Board should be established to advise the Commissioner of Rehabilitation on policy and program development. The Board should hold regular public hearings throughout the Commonwealth to determine needs and priorities for rehabilitation services.

AREA REHABILITATION ADVISORY BOARDS

10. An Area Rehabilitation Advisory Board should be established within each of the 37 proposed geographic service areas. The Board should advise the Area Rehabilitation Director on local needs and priorities for rehabilitation services and assist in the development of rehabilitation resources.

PROCEDURE FOR APPOINTMENT OF COMMISSIONER

11. The Governor should consult with a select committee of the State Rehabilitation Advisory Board prior to the appointment of a new Commissioner of Rehabilitation. The committee should advise the Governor on candidates for appointment and their relative qualifications.

Reorganization of the Massachusetts Commission for the Blind

RETENTION OF INDEPENDENT STATUS

12. The independent status of the Massachusetts Commission for the Blind should be retained to insure the provision of comprehensive social, financial, and rehabilitation services to blind and visually handicapped persons pending the creation of a single state agency to provide such programs for all disabled persons.

STATE OFFICE REORGANIZATION

13. The state office of the Massachusetts Commission for the Blind should be reorganized to strengthen top level administration and to separate administratively the provision of social and rehabilitation services from financial assistance programs.

PRINCIPAL POSITIONS

14. Principal positions should be the Commissioner, Deputy Commissioner, an Assistant to the Commissioner for Public Affairs, and four Assistant Commissioners for: Planning, Training, and Research; Rehabilitation Services; Health, Social, and Individual Services; and Administrative Services.

Qualifications and Salaries for Principal Administrative Positions

QUALIFICATIONS

15. New appointees to all principal administrative positions should possess the educational background and the administrative and professional experience necessary for effective administration of an expanding public agency employing large numbers of professional personnel.

SALARIES

16. Salaries for all principal positions should be maintained at a level commensurate with their responsibilities. At the present time, annual salaries should be not less than $25,000 for the Commissioner, $22,000 for the proposed Deputy Commissioners, and $18,000 for the proposed Assistant Commissioners.

Establishing Standards and Rates for the Purchase of Rehabilitation Services

REHABILITATION FACILITIES BOARD

17. Legislation should be enacted to establish a state Rehabilitation Facilities Board which would designate the proposed area disability evaluation centers, area sheltered workshops, and area work evaluation and adjustment centers. The Board should also establish standards and set rates for all nonmedical rehabilitation services purchased by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind.

Interdepartmental Coordination of Rehabilitation Services

REHABILITATION COORDINATING COUNCIL

18. A state Rehabilitation Coordinating Council should be established to promote interdepartmental coordination in the planning and provision of rehabilitation programs. Members should include agency heads or designated representatives from all state agencies having responsibility for physically, mentally, or socially handicapped persons and from the state Executive Office of Administration and Finance.

AN OVERVIEW

Enactment of the 1965 and 1968 amendments to the federal Vocational Rehabilitation Act resulted in major additions and expansions to the federal-state partnership for rehabilitating handicapped persons. New services can be offered, such as extended evaluations to determine rehabilitation potential. New categories of handicapped persons such as drug addicts, alcoholics, public offenders, and the socially disadvantaged can now be included within vocational rehabilitation programs. To finance these new and expanded activities, federal funds allotted to Massachusetts have tripled since 1965. By fiscal year 1976, if available federal monies are fully utilized, the total budget for vocational rehabilitation in Massachusetts should exceed $55 million. With this budget, rehabilitation services can be provided to more than 40,000 disabled and disadvantaged persons each year.

With such increased support from the federal government and with the urgent need for expansion of rehabilitation efforts, high priority should be given to planning for the administration of rehabilitation services. This section focuses on five major administrative topics:

- Reorganization and decentralization of the Massachusetts Rehabilitation Commission
- Reorganization of the Massachusetts Commission for the Blind.
- Salaries and qualifications for principal administrative positions.
- Standards and rates for the purchase of rehabilitation services.
- Interdepartmental coordination of rehabilitation services.

REORGANIZATION AND DECENTRALIZATION OF THE MASSACHUSETTS REHABILITATION COMMISSION

STATE OFFICE REORGANIZATION

The Massachusetts Rehabilitation Commission was established in 1956 as the st te's vocational rehabilitation agency replacing the Division of Vocational Rehabilitation in the Department of Education. The Commission is charged with responsibility for "the vocational rehabilitation of all handicapped persons, except the blind." G.L. c 6, § 75. Since 1956, the Commission has substantially expanded its programs to include not only physically disabled persons, but also chronically ill, mentally ill, and mentally retarded persons, alcoholics, drug addicts, and public offenders. Plans are now underway to extend vocational rehabilitation services to socially disadvantaged persons.

To permit effective administration of these new and rapidly expanding programs, a major reorganization of the Massachusetts Rehabilitation Commission should be undertaken. As a part of that reorganization, some of the duties of the present Client Services Section should be redistributed among other staff sections to achieve a more balanced organizational structure. In addition, positions for major staff supervisors should be upgraded to the level of Assistant Commissioner to reflect the increased scope and responsibility of the Commission's activities.

The state office of the Massachusetts Rehabilitation Commission should be organized into four major sections as shown in Chart 1: Planning, Training, Research, and Education; Community Programs; Client Services; and Administration. Each section should be directed by an Assistant Commissioner. The state office should also contain a Disability Adjudication Section headed by a Director. A permanent part time position of Legal Counsel should also be established.

COMMISSIONER OF REHABILITATION

The Commissioner of Rehabilitation should be the executive head of the agency with broad power to organize the Commission into such divisions, sections, and bureaus as are necessary for effective operation. Future administrative flexibility should not be limited by any rigid form of organization. The Commissioner should have the power to establish policies and procedures consistent with the general legislative mandate to the agency.

DEPUTY COMMISSIONER

During the last decade, the Massachusetts Rehabilitation Commission's activities have expanded to the point where a full time administrator is required to assist the Commissioner in the supervision of the agency's operations. Recognizing this need, the position of Special Assistant to the Commissioner was established by executive action. However, present state statutes covering the Massachusetts Rehabilitation Commission make no provision for anyone to act for the Commissioner during his absence. Responsibility in such a situation should be clearly defined. The position of Deputy Commissioner should be established by statute, with the authority to act for the Commissioner in his absence. The Deputy Commissioner should perform those functions now delegated to the Special Assistant to the Commissioner.

Because of the need for close working relations between these two individuals, the Commissioner should appoint his own Deputy Commissioner. The position should not be subject to civil service laws, but if the Commissioner selects an individual who is holding a civil service position, his rights and benefits should be protected during the period that he serves as Deputy Commissioner.

PLANNING, TRAINING, RESEARCH AND EDUCATION SECTION

All long and short range planning and operational evaluation, training and recruitment, research, and communication and education activities should be consolidated under the direction of an Assistant Commissioner for Planning, Training, Research, and Education. The four units within the section should work closely together to improve the Commission's relations with the university community, private and public health and welfare agencies, and the public at large.

Planning Unit

Although this report marks the completion of a major planning effort, continuing emphasis should be given to the planning function within the Massachusetts Rehabilitation Commission. Staff of the planning unit should be headed by a Director of Planning. Duties of the planning staff should include conducting studies to improve overall management and operation of the agency, developing long and short range management and service goals for the agency, devising new indicators to measure agency and personnel effectiveness, collecting data on the unmet needs of handicapped persons, and devising methods to extend and improve the agency's service.

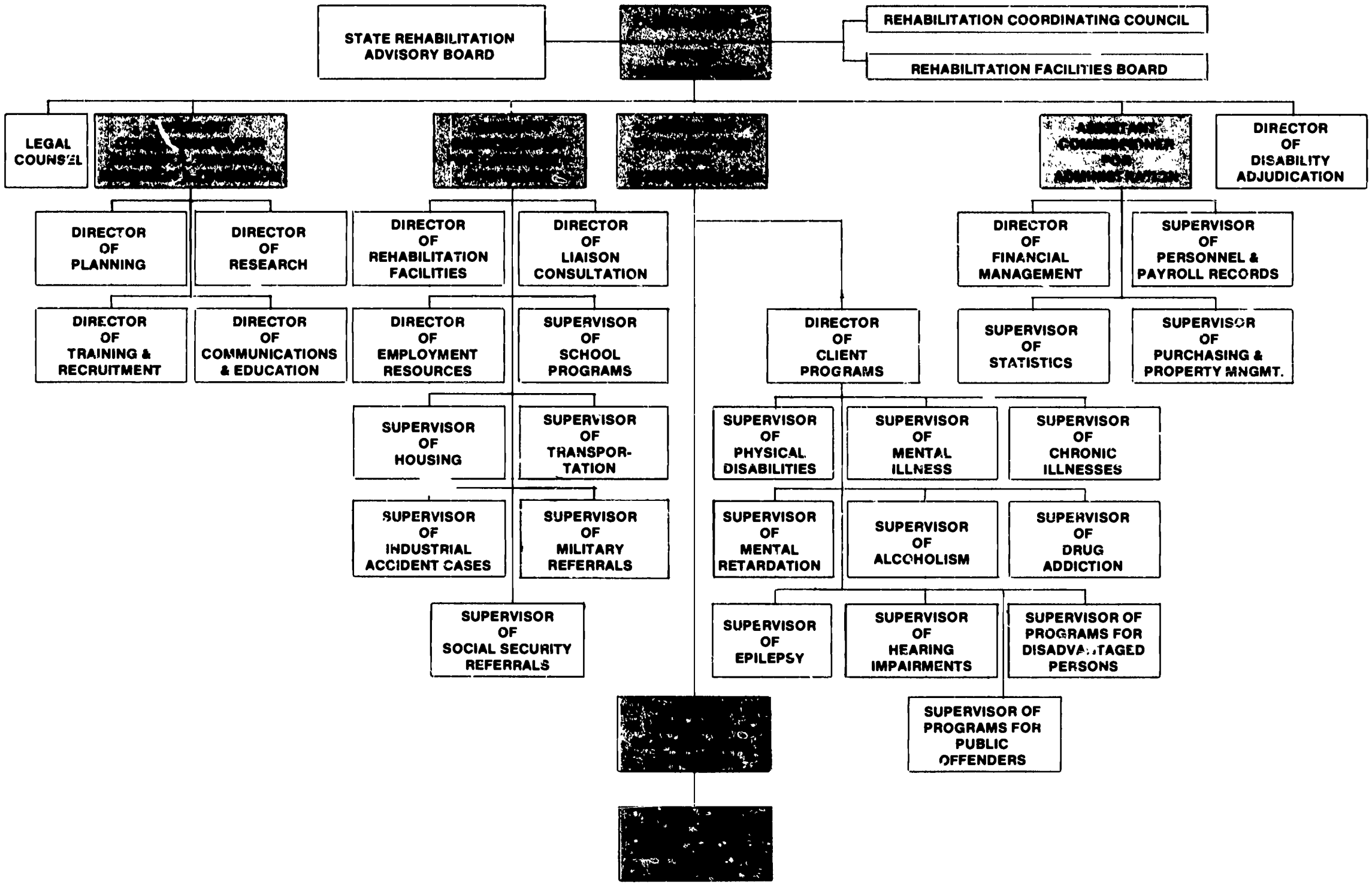
Training and Recruitment Unit

By 1976, the Massachusetts Rehabilitation Commission should expand its staff to more than 1,600 persons. A continuing training effort will be necessary to keep all personnel abreast of new problems, ideas and techniques. A high quality recruiting program should also be maintained if the

CHART 1

PROPOSED ORGANIZATION CHART - MASSACHUSETTS REHABILITATION COMMISSION

PRINCIPAL ADMINISTRATIVE POSITIONS



Commission intends to attract sufficient personnel to meet this manpower goal and fulfill its mandate for service to all handicapped citizens. A Director of Training and Recruitment should be in charge of these activities.

Although the staff of this unit should be responsible for the planning of training programs and seminars, personnel from both within and outside the agency should be utilized as principal lecturers. Likewise, other agency personnel should assist in campus recruiting activities. Training personnel should also stimulate the delopment of training institutes and short courses by universities for the continuing education of agency personnel as well as the rehabilitation staff of other public and private agencies.

Research Unit

A Director of Research should head an expanded research program within the Massachusetts Rehabilitation Commission. Staff of the research unit should provide consultation to agencies and individuals concerning their proposals for research projects, process applications for grants to support research activities, maintain a central research registry and library, and conduct research projects.

Communications and Education Unit

The Massachusetts Rehabilitation Commission should give increased emphasis to communications and education activities. A Director of Communications and Education should supervise a comprehensive public education program directed at the general public, handicapped persons, health, education and social service professionals, as well as personnel working directly in the field of rehabilitation. Research on public awareness and attitudes should be conducted to evaluate the success of various programs.

COMMUNITY PROGRAMS SECTION

A major expansion of resources is absolutely essential if the Massachusetts Rehabilitation Commission is to meet the service levels recommended for 1976. The Community Programs Section of the state office should be responsible for establishing policies, providing central direction, and rendering technical assistance to staff at the area level on the development of new rehabilitation resources and referral mechanisms essential to a comprehensive area rehabilitation program. The section should be directed by an Assistant Commissioner for Community Programs.

Rehabilitation Facilities Unit

A major resource in serving the handicapped are the private nonprofit rehabilitation facilities (both rehabilitation centers and sheltered workshops) located throughout the Commonwealth. Rehabilitation facilities provide a wide variety of evaluation, adjustment, training, placement and followup services to ever increasing numbers of handicapped persons. The Director of Rehabilitation Facilities should be responsible for all activities related to the Commission's use of rehabilitation facilities in providing services to its clients. Staff of the Rehabilitation Facilities Unit should analyze rate and program proposals and financial statements submitted by the disability evaluation centers, sheltered workshops, and work evaluation and adjustment centers prior to their submission to the proposed Rehabilitation Facilities Board. The unit should provide technical assistance to facilities in the preparation and revision of programs and in the establishment of proper accounting and financial management controls. Staff should also conduct periodic checks on programs and financial records.

In addition, the Rehabilitation Facilities Unit should review and process applications for construction, equipment, staffing, and training grants submitted by various facilities. Federal regulations require that these applications be approved by the Commissioner of Rehabilitation before they are forwarded to the Rehabilitation Services Administration of the United States Department of Health, Education, and Welfare. The unit should also provide encouragement and assistance to agencies to stimulate the expansion of needed rehabilitation resources. The relationship between the rehabilitation facilities unit and the proposed Rehabilitation Facilities Board is discussed later in this section.

Employment Resources Unit

A Director of Employment Resources should promote the hiring of handicapped workers throughout the state through his personal activities and the use of mass media. He should maintain liaison with top executives of large statewide employers, trade associations, and labor organizations, provide assistance to area placement specialists in their attempts to develop placement resources, and participate in the inservice training of counselors in the techniques of placement. He should also coordinate employment activities of the Massachusetts Rehabilitation Commission with those of the Division of Employment Security and the Massachusetts Commission on Employment of the Handicapped.

Housing Unit

A Housing Supervisor with a background in both public and private housing should provide assistance to area level personnel responsible for expanding housing resources for the disabled. Assistance should include information on housing laws and programs and real estate practices, methods to achieve greater community interest and involvement, construction techniques for overcoming architectural barriers, and guidance on the planning and construction of specialized housing.

Transportation Unit

The proposed state program for transportation subsidies to enable severely disabled persons to go to and from work and participate in the activities of everyday living should be implemented by a Transportation Supervisor. He should develop necessary regulations and procedures for the program and guide area staff in setting up their programs. In addition, he should provide advice and assistance to area level personnel in helping medical, educational, and social service agencies plan transportation programs to enable disabled persons to utilize their services.

School Programs Unit

A School Programs Supervisor, with a considerable background in the field of education, should attempt to increase the number of vocational, technical and higher educational institutions which will accept disabled students and encourage the schools to make adjustments in their programs to meet the special needs of these students. He should also provide advice and financial assistance on matters such as removing architectural barriers and for providing communications equipment for home or hospital instruction.

Liaison Consultation Unit

In addition to programs for the development of rehabilitation resources, the Community Programs Section should be responsible for statewide direction of the Liaison Consultant program. Liaison consultants within each area rehabilitation office should provide consultation to agencies and individuals who come into contact with handicapped persons and thus are potential alerting stations. As alerting stations, these agencies and individuals should find persons who are in need of vocational rehabilitation services and refer them to the appropriate rehabilitation agency. A Director of Liaison Consultation should supervise the program.

Industrial Accident Cases Unit

A Supervisor of Industrial Accident Cases should be included within the Community Programs Section to serve as the representative of the Commissioner of Rehabilitation of the Industrial Accident Rehabilitation Board. The Board is responsible for reviewing plans for the rehabilitation of industrially injured workers. This person should coordinate the activities of the Industrial Accident Board, the Industrial Accident Rehabilitation Board, and the area rehabilitation offices to extend rehabilitation services to larger numbers of industrially disabled persons.

Military Referral Unit

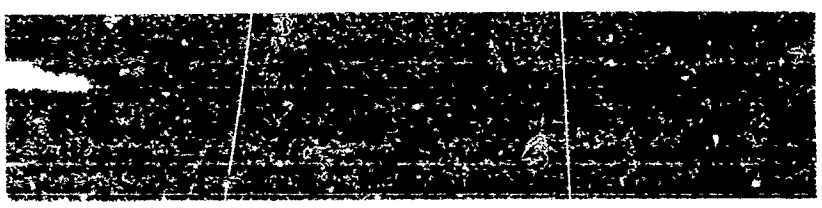
The operation of screening units at the Armed Forces Entrance and Examining Stations in Boston and in Springfield should be directed by a Supervisor of Military Referrals. These units should utilize records of military entrance exams and personal interviews to determine whether persons rejected by the military service because of physical or mental deficiencies could benefit from a program of rehabilitation services. Similar screening activities should be established in cooperation with all local draft boards to discover more severely handicapped youths who are rejected for service without a preinduction examination. After screening, such persons should be referred to area rehabilitation offices for service.

Social Security Referrals Unit

A Supervisor of Social Security Referrals should coordinate the Commission's efforts to rehabilitate applicants for disability benefits under the Social Security Act. Increased efforts should be made to provide rehabilitation services to a larger percentage of applicants. Initial referral should be made to local area rehabilitation offices as soon as possible rather than waiting until the claim is fully processed. As additional information is obtained, it should be relayed to the local office. Appropriate training should be provided to case examiners to qualify them to make direct referrals to area rehabilitation offices. All costs of this program are paid out of the Social Security Trust Fund and maximum benefit should be obtained for the disabled citizens of the Commonwealth.

CLIENT SERVICES SECTION

The Client Services Section of the state office should be responsible for all activities related to the provision of case services. The section should be directed by an Assistant Commissioner for Client Services who should supervise the regional and area rehabilitation directors located throughout the Commonwealth. As such, he should spend considerable time in the various regions and areas evaluating the performance of subordinate units. A Director of Client Programs and ten Client Program Supervisors should be concerned with the development of improved and expanded case service methods and operations and with evaluating services which are provided to individual clients and to various disability groups.



Client Program Units

Client Program Supervisors within the Client Services Section should be specialists in the following areas: Physical Disabilities, Mental Illness, Mental Retardation, Chronic Illnesses, Epilepsy, Hearing Impairments, Alcoholism, Drug Addiction, Programs for Public Offenders, and Programs for Disadvantaged Persons.

The Client Program Supervisors should be the most knowledgeable persons in the Commission concerning the unique problems of rehabilitating handicapped persons within their specialty. As such, they should provide consultation to case service personnel in the area rehabilitation offices and should monitor the quality of services provided to clients within their specialty area. These supervisors should also conduct training of counselors (planned by the Director of Training and Recruitment) in the techniques of rehabilitation of persons within their specialty.

Client Program Supervisors should also coordinate and initiate expansion of services to handicapped persons within their specialty area in conjunction with the area rehabilitation staff. They should serve as the coordinating links between the Massachusetts Rehabilitation Commission and other state departments and agencies having responsibility for persons within their specialty area. For example, the Supervisor of Programs for Disadvantaged Persons should coordinate with the Department of Public Welfare, the Division of Employment Security, and the state's antipoverty agencies. The object of this coordination should be to eliminate any gaps in services, to improve client referral to appropriate services, and to institute joint programs.

The supervisors should work closely with voluntary associations related to their specialty area. For example, the Supervisor of Mental Retardation should maintain close contacts with the Massachusetts Association for Retarded Children. This close relation will improve public knowledge of the Massachusetts Rehabilitation Commission's programs and help insure that potential clients will be expeditiously referred for service.

ADMINISTRATION SECTION

An Assistant Commissioner for Administration should be responsible for the rapidly growing fiscal and administrative activities of the Commission. These activities include personnel and civil service, payroll, budgeting, accounting, purchasing, property, and statistical reports on agency operations.

Personnel and Payroll Records Unit

A Personnel and Payroll Records Unit should prepare and maintain all personnel, civil service, and payroll records and reports for the 1,600 employees anticipated by 1976. A Supervisor of Personnel and Payroll Records should direct the operation of the unit and be responsible for liaison and coordination with the state Division of Civil Service on such matters as civil service examinations, reclassification of positions, preparation of job descriptions, and the addition of new positions. Efforts to convert all temporary positions at the Commission to permanent positions should continue to be emphasized.

Fiscal Management Unit

A Director of Fiscal Management should supervise all accounting and budgetary activities except for payroll expenditures. In fiscal year 1968 the Massachusetts Rehabilitation Commission purchased more than $3.5 million worth of vocational rehabilitation services for its clients. By 1976 these amounts should increase fourfold. Extensive records must be maintained to comply with state purchasing regulations in all these transactions. The Director of Fiscal Management should also be responsible for the technical training and supervision of fiscal personnel in each of the area rehabilitation offices. As the Commission expands, fiscal management activities will become an even more important management tool for insuring that all funds are being spent in the most effective manner.

Purchasing and Property Management Unit

A Purchasing and Property Management Unit should be responsible for the purchasing of all types of equipment and supplies for the Commission's use and for various types of equipment for use by clients at hospitals and rehabilitation facilities. The Supervisor of Purchasing and Property Management should oversee the maintenance of records on all Commission property to insure accountability according to state and federal regulations. Negotiations with owners and contractors for the rental of office space and associated maintenance activities for the Commission's offices throughout the Commonwealth should be the responsibility of this unit.

Statistical Unit

The collection, processing, and reporting of data on all aspects of the Commission's operations should be the responsibility of a Supervisor of Statistics. Data should be available to the Commissioner and staff for management planning and research activities. Qualified researchers and planners outside the Commission should also have access to such data, with any confidential information protected. The statistical unit should prepare all reports on agency operations for the federal government. Automatic data processing equipment should be utilized for statistical operations as soon as practical to permit expanded use of the Commission's statistical data.

REGIONAL REHABILITATION OFFICES

Regional rehabilitation offices should be established in each of the seven proposed administrative regions to provide effective day to day field supervision of the activities of the 37 proposed area rehabilitation offices. Regional Rehabilitation Directors should be responsible to the Assistant Commissioner for Client Services and serve as the intermediaries between the Area Rehabilitation Directors and the state office personnel.

Regional Rehabilitation Directors should play an important role in establishing new area rehabilitation offices. They should advise on the appointment of area rehabilitation directors and provide extensive assistance and counsel during their first few months of duty. The Regional Rehabilitation Directors should serve as general troubleshooters throughout the areas within their region. Their focus should be that of a generalist, looking at the overall operation while state office specialists focus on specific programs such as housing or services to the mentally retarded. Regional Rehabilitation Directors should verify that the Commission's standards are being maintained and that program and service goals are being achieved.

Because of the annual difficulties faced by certain disability groups, specially trained counselors are needed to provide rehabilitation services to them. However, because of the small number of clients involved, it might not be practical to provide the needed training to counselors within every area. An example of this situation would be counselors trained to work with deaf persons. To meet this need and others similar to it, specially trained counselors should be assigned to work throughout the region. These counselors should be supervised by the Regional Rehabilitation Director rather than by any one of the Area Rehabilitation Directors.

AREA REHABILITATION OFFICES

At the present time, the Massachusetts Rehabilitation Commission provides services to clients through nine district offices throughout the Commonwealth. Seven subdistrict offices have been established within various districts for the convenience of clients. However, subdistrict offices have no administrative or program responsibility and are merely branches of the parent district office.

Under present operating procedures, district offices only provide case services to clients as they are referred. Responsibility for the development of new rehabilitation resources for expansion of client services and for the development of new referral mechanisms and cooperative programs is centralized at the state office.

To provide services at the local community level, the larger and more remote district offices should be replaced by area rehabilitation offices. Each area rehabilitation office should be a complete administrative and service unit responsible for providing needed rehabilitation services to all handicapped persons residing within the area. Because each office will serve a much smaller territory, the staff should be able to become a part of the area community. When the area rehabilitation office becomes a part of the community, a larger number of citizens will be aware of the Massachusetts Rehabilitation Commission and its programs (improved visibility) and handicapped citizens can more easily take advantage of the services offered because of its close proximity (improved access).

In addition to providing direct client services, area rehabilitation offices should be responsible for developing new resources within the area and for developing mechanisms and programs for improved casefinding and for the referral of clients to appropriate rehabilitation services. State office personnel from the Community Programs Section should provide guidelines for the operation of these programs as well as guidance and consultation to area staff. They should also provide periodic evaluations to Area and Regional Rehabilitation Directors as well as to the Commissioner of Rehabilitation on the operation of programs within the areas.

The area rehabilitation offices should also have the responsibility for planning programs based on its knowledge of local needs and resources. Area staff in consultation with the Area Rehabilitation Advisory Board should prepare their own annual plan and budget, as well as their annually updated five year plan, each based on an annual needs-resources survey. These documents should be forwarded to the Regional Rehabilitation Director for comment and evaluation and then to the Commissioner for his review and approval after consultation with his staff and the State Rehabilitation Advisory Board. Once approved, they should be used by area staff as basic operating documents of the year.

A more detailed description of area organization and functions is contained in the section entitled Providing Comprehensive Rehabilitation Services in the Community.

STATE REHABILITATION ADVISORY BOARD

Citizen participation in the programs of the Massachusetts Rehabilitation Commission is presently accomplished through its Advisory Council. The Council is composed of 14 members, nine of whom are the heads of varous state agencies concerned with problems related to rehabilitation. The other five members are persons "qualified by training, experience or demonstrated interest in the vocational rehabilitation of handicapped persons." G.L. c.6, § 76.

The Advisory Council should be split into two separate bodies, each performing quite different functions. A state Rehabilitation Coordinating Council, discussed later in this section, should be established to coordinate the activities of the various state departments concerned with rehabilitation. A State Rehabilitation Advisory Board should be established to provide expanded citizen and consumer involvement in rehabilitation programs. The Board should perform the following duties:

- Advise the Governor on the appointment of the Commissioner of Rehabilitation.

- Advise the Commissioner on policy, program development, and priorities of need for rehabilitation services.
- Serve as a liaison between the several rehabilitation regions and the Massachusetts Rehabilitation Commission.
- Participate with the Massachusetts Rehabilitation Commission in regularly scheduled public hearings throughout the state.
- Review the annual plan, the annually revised five year plan, the annual budget and the annual needs-resource survey of the Massachusetts Rehabilitation Commission.
- Submit an annual report of activities to the Governor.

The State Rehabilitation Advisory Board should be composed of 15 members appointed by the Governor after consultation with the Commissioner. Membership of the Board should include at least one member from an Area Rehabilitation Advisory Board within each of the rehabilitation regions. Members should be persons with demonstrated interest and concern for the welfare of handicapped persons. Handicapped persons should be included in the membership.

Members of the Board should be appointed to three year staggered terms. The Board should elect its own chairman and hold regular monthly meetings. The Commissioner, or in his absence the Deputy Commissioner, should attend all meetings of the Board. If any member of the Board is absent for three consecutive regularly scheduled monthly meetings, his office as a member of the Board should be deemed vacant. The chairman of the Board should notify the Governor when such a vacancy exists.

Members should serve without compensation, but should be reimbursed for necessary expenses incurred in the performance of their duties. Reimbursement should include expenses to attend meetings of the Board, inspect rehabilitation offices or facilities, conduct public hearings and perform any other activities. Clerical staff and supplies for the use of the Board should be furnished by the Commissioner of Rehabilitation.

AREA REHABILITATION ADVISORY BOARDS

Each of the 37 proposed geographic service areas should have an Area Rehabilitation Advisory Board to perform the following functions:

- Identify local needs for rehabilitation services.
- Advise the Area Rehabilitation Director on policy and program priorities for the improvement of rehabilitation services.
- Serve as liaison between the local community(ies) and the area rehabilitation staff.
- Review the area's annual plan and annual budget and append their comments thereto.
- Submit an annual report of activities to the Commissioner of Rehabilitation.
- Maintain liaison with the community mental health and retardation area board and the community service board (public welfare).

Area boards should be composed of seven members appointed by the Commissioner of Rehabilitation. Members should either live or work within the geographic service area and should represent as many different cities and towns as is practicable. Members should be drawn from citizens with a demonstrated interest and concern for the welfare of handicapped persons. Handicapped persons should be included in the membership.

Members should be appointed to three year staggered terms. Area boards should elect their own chairman and hold regular monthly meetings. The Area Rehabilitation Director, or in his absence a principal subordinate, should attend all meetings of the Board.

If any member of the Board is absent for three consecutive regularly scheduled monthly meetings, his office as a member of the Board should be deemed vacant. The chairman of the Board should notify the Commissioner when such a vacancy exists. Members of the Board should serve without compensation. Clerical staff and supplies for the use of the Board should be furnished by the Area Rehabilitation Director.

PROCEDURES FOR APPOINTMENT OF COMMISSIONER

In 1967, the General Court enacted legislation making the term of the Commissioner of Rehabilitation and most other state agency heads coterminous with that of the Governor. Therefore, every four years consideration will be given to a new appointment. With such a large number of appointments being considered, some mechanism should be provided to assist the Governor in finding qualified candidates for the position and to give him assistance in evaluating their relative qualifications. However, this mechanism should not intrude on the Governor's right, as the responsible officer of the executive branch, to appoint the man of his choice.

The State Rehabilitation Advisory Board should provide this mechanism. In the year of a gubernatorial election, the board should elect a three member committee for the purposes outlined above. Following the election, the committee should meet with the Governor or the Governor-elect as the case may be. At that time, the committee should secure from him the names of all candidates whom he is considering for appointment. The committee should then gather the names of other possible candidates for the position. Their search should extend to other states and the federal government as well as private rehabilitation agencies.

After completing its search, the committee should render a report to the Governor or Governor-elect covering all the candidates proposed. The report should include a resume of the qualifications of each candidate and an evaluation opinion of their qualifications by the committee. As to each of the proposed candidates, the committee should render an overall advisory opinion stating whether they believe the individual to be either "highly qualified," "qualified," or "unqualified" for appointment as Commissioner of Rehabilitation. After receiving the report, it should be the Governor's prerogative to appoint any of the men suggested by himself or by the committee.

REORGANIZATION OF THE MASSACHUSETTS COMMISSION FOR THE BLIND

RETENTION OF COMPREHENSIVE AGENCY FOR THE BLIND

The Massachusetts Commission for the Blind was established by the General Court in 1966 to provide comprehensive social and rehabilitation services as well as financial and medical assistance to all blind persons in the Commonwealth. Prior to establishment of the Commission, the Division of the Blind within the Department of Education was charged with these responsibilities. As an independent agency, the activities of the Commission have become more visible to the public and its policy making process has been streamlined.

The comprehensive nature of the Commission is of considerable advantage to the individual blind person. Once initial contact has been established, the client's total social, financial, and rehabilitation needs can be served. He does not have to seek help from a multitude of agencies.

For the newly blinded person, the Commission provides a home teacher to assist him in learning to function as a blind person, i.e., becoming independently mobile and learning to communicate by telephone or typewriter. At the same time, a social case worker provides guidance and counseling to the individual and to his family to ease the psychological adjustment to his blindness. Only after the individual has become emotionally and functionally adjusted to his blindness can the vocational rehabilitation process begin. This interim adjustment period often takes two years or more.

When the blind person is ready to take advantage of more complex rehabilitation training, the caseworker introduces the rehabilitation counselor who then takes responsibility for achieving the ultimate goal of vocational rehabilitation and placement. During this entire period, the Commission also provides financial or medical assistance to enable clients to meet their basic needs. This unique team approach to serving the total needs of the blind individual has proven itself to be very successful.

The Planning Commission considered two basic alternatives to the present administrative structure. The first alternative would be to combine the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind into a single agency. This alternative is often proposed in the belief that the two agencies fulfill the same basic responsibilities to their respective clientele. The difficulty with this alternative is that, actually, the scope of the Massachusetts Commission for the Blind is considerably broader than that of the Massachusetts Rehabilitation Commission. The Massachusetts Commission for the Blind provides comprehensive social, financial, and rehabilitation services over the course of a blind individual's entire lifetime, while the Massachusetts Rehabilitation Commission provides only rehabilitation services and retains its clients for only a limited period of time. A unification and integration of the two agencies as presently constituted would not be practical because of these differences in programs and philosophy. In addition, little monetary benefit would result from consolidation of the agencies since there are no duplications of services or programs which could be thus eliminated.

The second alternative would be to transfer only the rehabilitation activities of the Massachusetts Commission for the Blind to the Massachusetts Rehabilitation Commission. This alternative would create a single state agency responsible for providing rehabilitation services to the blind as well as to all other handicapped persons. However, it would result in the administrative separation of rehabilitation programs from the social service and financial assistance programs for the blind, which would still have to be performed by the Commission or some other agency. The individual blind person would then have to deal with two agencies rather than one. Neither would be responsible for his total needs.

Therefore, the Planning Commission recommends that the present administrative structure be retained pending a major reorganization of health, welfare, and rehabilitation services. Such a reorganization should use the Massachusetts Commission for the Blind as a prototype for the creation of an agency which would provide comprehensive social financial, and rehabilitation services to all disabled persons. At that time, the Massachusetts Commission for the Blind should become an integral part of the comprehensive agency.

REORGANIZATION OF THE COMMISSION

The Massachusetts Commission for the Blind should be reorganized to strengthen top level administration by establishing the position of Deputy Commissioner and four Assistant Commissioners, and to separate administratively the provision of social and rehabilitation services from programs of financial and medical assistance.

The work of the Commission should be reorganized into four major sections as shown in Chart 2: Planning, Training and Research; Rehabilitation Services; Health, Social and Individual Services; and Administrative Services. Each section should be directed by an Assistant Commissioner. In addition, a Public Affairs section, headed by an Assistant to the Commissioner, and a permanent part time position of Legal Counsel to the Commission should be established.

COMMISSIONER FOR THE BLIND

As executive head of the agency, the Commissioner for the Blind should have broad authority to organize the Commission into such divisions, sections, and bureaus as are necessary for effective operation. Future administrative flexi-

bility should not be limited by any rigid statutory form of organization. The Commissioner should also have the power to establish policies and procedures consistent with the general legislative mandate to the agency.

DEPUTY COMMISSIONER

Because of the growth of the commission, a Deputy Commissioner is needed to assist the Commissioner in overall supervision of agency activities. In addition, present statutes covering the Massachusetts Commission for the Blind do not provide for any person to act for the Commissioner in his absence. The Deputy Commissioner should be so authorized. The Deputy Commissioner should be appointed by the Commissioner and should serve at his pleasure. If the individual is appointed from a civil service position, his civil service rights and benefits should be protected while serving as Deputy Commissioner.

PLANNING, TRAINING AND RESEARCH SECTION

All planning, training and recruitment, and research activities at the Massachusetts Commission for the Blind should be directed by an Assistant Commissioner for Planning, Training and Research. The discussion as to the nature and importance of these functions at the Massachusetts Rehabilitation Commission applies equally to the Massachusetts Commission for the Blind. Principal positions should be established to supervise activities in each functional area, namely: a Supervisor of Planning, a Director of Training and Recruitment, and a Supervisor of Research.

REHABILITATION SERVICES SECTION

At the present time, rehabilitation activities at the Commission are divided between the Bureau of Rehabilitation and the Bureau of Industries. These two separate Bureaus should be brought together to place all rehabilitation activities under the supervision of an Assistant Commissioner for Rehabilitation Services. The Rehabilitation Services Section should include four separate units: Rehabilitation Counseling, Business Enterprises, Industries, and Rehabilitation Facilities and Special Programs.

Rehabilitation Counseling Unit

Comprehensive rehabilitation services leading to successful vocational placement should be available to all blind persons who could benefit from them. The Director of Rehabilitation Counseling should supervise the provision of counseling services and comprehensive evaluation, medical restoration, vocational training, job placement, and followup services. An increased number of rehabilitation counselors and supervisors will be necessary to provide these vital services. Close working relations should be maintained between rehabilitation counselors, social workers, and home teachers.

Business Enterprises Unit

A greatly expanded program of small business enterprises for blind persons should be established under the supervision of the Director of Business Enterprises. In 1968, 42 vending stands were in operation with average annual earnings for the operator of $6,034. This program should be expanded to include other types of small, independent businesses. The Business Enterprises Unit should negotiate and develop new opportunities for businesses, design and construct necessary facilities, train operators, and provide technical and management assistance to insure successful operation.

Industries Unit

Under the direction of a Supervisor of Industries, the Commission's sheltered workshops should provide extended sheltered employment for blind persons who are unable to compete successfully in the labor market. These workshops enable workers to become productive, self-supporting members of their communities. Workshops located in Cambridge, Lowell, Fall River, Worcester, Springfield and Pittsfield produce products such as brooms, mops, rubber mats, and handwoven articles. If necessary, expansion should be undertaken in order to provide work opportunities for all blind persons.

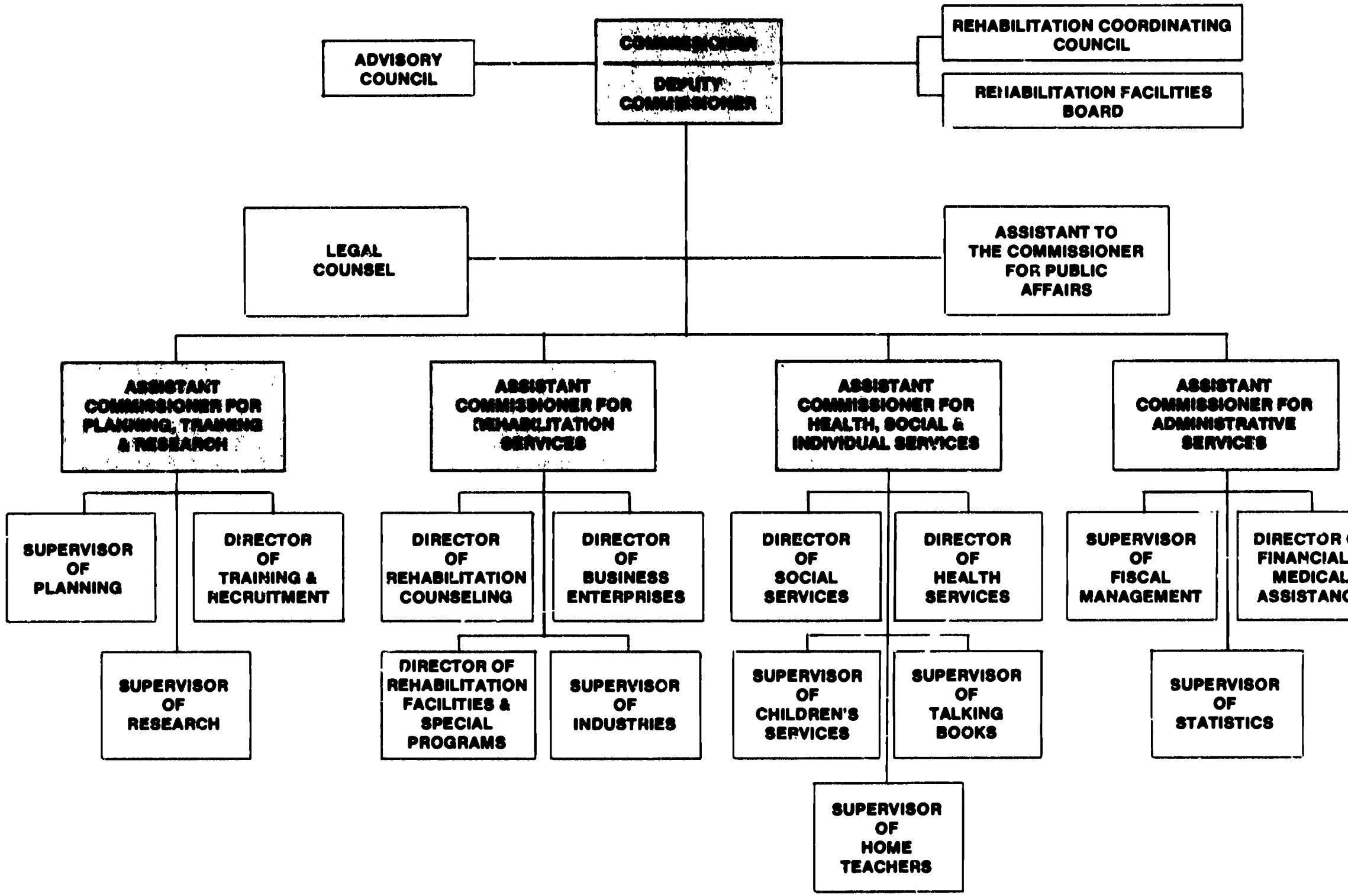
Rehabilitation Facilities and Special Programs Unit

A Director of Rehabilitation Facilities and Special Programs should be responsible for the development of new training programs for hard to serve clients such as the retarded blind and the development of new job opportunities in occupations which have previously been closed to blind persons such as public school teaching. This unit should also be responsible for all activities related to the Commission's use of rehabilitation facilities in providing services to its clients. Staff should perform duties similar to those of the Rehabilitation Facilities Unit of the Massachusetts Rehabilitation Commission. The Rehabilitation Facilities and Special Programs Unit, and its relationship to the Rehabilitation Facilities Board, is discussed later in this section.

CHART 2

PROPOSED ORGANIZATION CHART — MASSACHUSETTS COMMISSION FOR THE BLIND

PRINCIPAL ADMINISTRATIVE POSITIONS



HEALTH, SOCIAL, AND INDIVIDUAL SERVICES SECTION

The provision of comprehensive social casework services under the federal Aid to the Blind program (Title X of the Social Security Act) should be administratively separated from the payment of financial assistance under the same act. Social service personnel and the present Bureau of Individual Services (home teachers, talking books, and children's services) should be responsible to an Assistant Commissioner for Social and Individual Services. Financial and medical assistance programs should be administered by the Administrative Services Section.

Social Services Unit

A comprehensive program of social casework services should be available to all blind persons under the supervision of a Director of Social Services. Staff of the Social Services Unit should provide counseling and assistance to blind persons and their families in overcoming the adjustment to blindness as well as referral to services in the Commission and in the community which can meet the particular needs of the individual blind person. A substantial increase in social workers is mandatory if adequate services are to be provided.

Health Services Unit

A Director of Health Services should supervise a program of health guidance for blind persons. Such service should be arranged either at the request of the individual client or upon referral by a social caseworker. Home health counselors should be able to evaluate the health problems of the person and, if necessary, make proper referral to appropriate medical treatment resources. A program of health guidance is required part of the federal Medicaid program.

Home Teaching Unit

An increased number of home teachers should be employed by the Massachusetts Commission for the Blind. A supervisor of home teachers should direct this program which provides training and counseling to newly blinded persons to help them adjust to their blindness and to perform everyday activities such as typewriting, moving around the home, braille reading and personal grooming. The existing close relationship between home teachers, social workers and rehabilitation counselors should be maintained.

Talking Books Unit

A supervisor of library services should direct an expanded program of talking books (long playing records). More than 3,000 different talking books are presently distributed from the regional unit of the Library of Congress at Watertown. In the future, talking books and talking book machines should be located at city and town libraries throughout the state where they would be more readily available to blind persons living in the vicinity. Local librarians should provide personal attention and professional consultation on a reading program.

Children's Services

A specialized program offering comprehensive social services and home teaching to blind children and their families should be directed by a Supervisor of Children's Services. In addition to social casework services and home teaching, staff of the Children's Services Unit provides consultation and assistance in planning and arranging educational programs for blind and visually handicapped children and helps to arrange summer camping experience.

ADMINISTRATIVE SERVICES SECTION

An Assistant Commissioner for Administrative Services should direct all fiscal and administrative operations of the Commission. These activities include personnel and civil service, payroll, budgeting, accounting, purchasing, property, and statistical reports on agency operations. In addition, the federal-state programs for financial and medical assistance to needy blind persons should be administered by the Administrative Services Section.

Fiscal Management Unit

All accounting, budgetary, and personnel activities within the Commission should be directed by a Supervisor of Fiscal Management. These activities should include civil service and payroll records and reports. In addition, all purchasing and property management activities should be the responsibility of the Supervisor of Fiscal Management.

Statistical Unit

The collection, processing, and reporting of data on the Commission's various social service, rehabilitation, and financial and medical assistance programs should be directed by a Supervisor of Statistics. This data should be available to the Commissioner and staff for management, planning and research activities and to qualified researchers and planners outside the Commission, with any confidential information protected. The Statistical Unit should prepare all reports on agency operations for the federal government. Automatic data processing equipment should be utilized in statistical operations to permit an expanded use of the Commission's statistical data.

Financial and Medical Assistance Unit

A Director of Financial and Medical Assistance should supervise the administration of programs for financial and medical assistance to the blind. The financial assistance program is operated under Title X of the Social Security Act, the federal Aid to the Blind program. The medical assistance program, popularly termed Medicaid, is administered under Title XIX of the Social Security Act.

Administration of these programs primarily involves eligibility determinations and subsequent financial payments. These duties should be administratively separated from the provision of social services. By employing case examiners to perform this function, social service professionals can concentrate their efforts on the provision of casework services.

PUBLIC AFFAIRS SECTION

A Public Affairs Section headed by an Assistant to the Commissioner for Public Affairs should be established at the Massachusetts Commission for the Blind. Responsibilities of this section should include communications and education activities and legislative and Congressional relations. Its operations should be similar to that of the Communications and Education Unit of the Massachusetts Rehabilitation Commission discussed earlier.

QUALIFICATIONS AND SALARIES FOR PRINCIPAL ADMINISTRATIVE POSITIONS

QUALIFICATIONS

Strong top level leadership will be required to enable the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to expand their services and programs to meet the challenges of the next decade. During that period, the number of persons receiving rehabilitation services should increase fourfold. Considerable effort should be expended towards rehabilitating hard to serve clients such as the severely or multiply disabled. More attention should be given to the disabilities of old age. In addition, the Massachusetts Rehabilitation Commission should become a major instrument for bringing socially disadvantaged persons back into the mainstream of American life.

The skills of staff at all levels will have to be upgraded and modernized to meet these new challenges. A greatly expanded inservice training effort will be required. Experienced staff will be needed to play a vital role in the professional orientation and supervision of new personnel. If projected service goals are to be attained, this experienced cadre will have to train more than 600 new professional personnel by 1976. For this reason, staff members must be up to date in their skills and be able to transmit this knowledge to young graduates. Improved opportunities for advancement as well as a stimulating professional atmosphere are essential if the retention rate of new personnel is to be raised. The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind cannot afford to train new personnel and subsequently lose them to other organizations.

In the decade ahead, all of the public human service agencies should be striving for closer cooperation to give better services to all the handicapped. Rehabilitation administrators at the state and local levels as well as individual counselors should be working as a close knit team with public health, mental health, social service, and education professionals. Over the last two decades, these other professions have increasingly recognized the rehabilitation counselor as a full partner in the professional team serving the disabled. This trend must continue if high quality interdisciplinary rehabilitation services are to be provided to handicapped persons.

In line with the movement towards higher professional standards within the fields of rehabilitation and social work, minimum education and experience levels should be established for all professional positions in the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind. Minimum qualifications for principal positions are shown in Charts 3 and 4.

Over the years a number of personnel at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind have acquired considerable knowledge from their practical experience in rehabilitation even though they lack formal academic training. For this reason, the educational requirements should be waived for persons whose continuous professional service began prior to January 1, 1964 (5 years of service). A greatly expanded program should be instituted to insure that opportunities for educational leave are provided to all personnel whose services began subsequent to that date.

SALARIES

If the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind are to retain and attract qualified administrators during the next decade, salaries at all levels will have to be increased. Although top level positions in both agencies were substantially enlarged in both scope and responsibility during the last five years, salaries were not correspondingly upgraded. For the five years from 1963 to 1968, the salary for the Commissioner of Rehabilitation has been frozen by statute at $13,000 per year.

Chart 3

SUGGESTED MINIMUM EDUCATION AND EXPERIENCE FOR PRINCIPAL ADMINISTRATIVE POSITIONS AT THE MASSACHUSETTS REHABILITATION COMMISSION

Position	*Suggested Minimum Experience*	*Suggested Minimum Education*
Commissioner	10 years in rehabilitation administration including 3 years of high level administrative responsibility	Master's in Rehabilitation — related field[1]
Deputy Commissioner	7 years in rehabilitation administration	Master's in Rehabilitation — related field
Assistant Commissioners: Planning, Training Research, and Education	5 years of experience related to planning, training, research, and education in human service agencies	Master's in Rehabilitation — related field
Community Programs	5 years of experience in developing and coordinating human services	Master's in Rehabilitation — related field
Client Services	5 years in rehabilitation administration	Master's in Rehabilitation — related field
Administration	5 years experience in business and fiscal management including 3 years of administrative responsibility	Master's in Business Administration
Director of Planning	4 years experience in planning for human service agencies	Master's in Rehabilitation — related field
Director of Training and Recruitment	4 years of practice in rehabilitation including substantial experience in training and recruitment	Master's in Rehabilitation — related field
Director of Research	4 years in conducting independent research including 2 years of research administration	Doctorate in the Social Sciences
Director of Communications and Education	4 years experience in health education or a related field	Master's in Education, Public Health, or Communications
Director of Rehabilitation Facilities	4 years experience in administration of rehabilitation centers and sheltered workshops	Master's in Rehabilitation — related field
Director of Liaison Consultation	4 years of practice in rehabilitation plus substantial experience in providing health and social services	Master's in Rehabilitation — related field
Director of Client Programs	4 years practice in rehabilitation including 2 years in rehabilitation administration	Master's in Rehabilitation — related field
Director of Fiscal Management	4 years experience in fiscal management including 2 years of administrative responsibility	Bachelor's in Business Administration
Supervisor of Statistics	4 years experience in a statistical unit including 2 years . administration of a statistical unit	Bachelor's in Statistics or Mathematics
Supervisor of Personnel and Payroll Records	4 years experience in records management	Bachelor's in Business Administration
Supervisor of Purchasing and Property Management	4 years experience related to purchasing and property management	Bachelor's in Business Administration
Client Program Supervisors[2]	4 years of practice in rehabilitation including 2 years experience in specialty or completion of a recognized specialty training program	Master's in Rehabilitation — related field
Community Programs Resource Supervisors[3]	4 years experience in specialized field	Master's in Rehabilitation — related field
Community Programs Referrals Supervisors[4]	4 years of practice in rehabilitation	Master's in Rehabilitation — related field
Regional Rehabilitation Directors	4 years of practice in rehabilitation including 2 years in rehabilitation administration	Master's in Rehabilitation — related field

[1]Such as Rehabilitation Counseling, Rehabilitation Administration, or Social Work, Psychology, Counseling and Guidance, Occupational Therapy, or Special Education, with a core program in rehabilitation.

[2]Physical Disabilities, Mental Illness, Mental Retardation, Chronic Illness, Epilepsy, Hearing Impairments, Alcoholism, Drug Addiction, Programs for Public Offenders, and Programs for Disadvantaged Persons.

[3]Transportation, Housing, School Programs, and Employment Resources.

[4]Industrial Accident Cases, Military Referrals, and Social Security Referrals.

Chart 4

SUGGESTED MINIMUM EDUCATION AND EXPERIENCE FOR PRINCIPAL ADMINISTRATIVE POSITIONS AT THE MASSACHUSETTS COMMISSION FOR THE BLIND

Position	*Suggested Minimum Experience*	*Suggested Minimum Education*
Commissioner	10 years in rehabilitation or social service administration of which 5 years is in an agency serving the blind including 3 years of high level administrative responsibility	Master's in a field related to Rehabilitation or Social Work[1]
Deputy Commissioner	7 years in rehabilitation or social service administration of which 4 years is in an agency serving the blind	Master's in a field related to Rehabilitation or Social Work
Assistant Commissioners:		
Planning, Training, and Research	5 years of experience related to planning, training, and research in human service agencies	Master's in a field related to Rehabilitation or Social Work
Health, Social, and Individual Services	5 years in social service administration of which 3 years is in an agency serving the blind	Master's in Social Work — related field
Rehabilitation Services	5 years in rehabilitation administration of which 3 years is in an agency serving the blind	Master's in Rehabilitation — related field
Administrative Services	5 years experience in business and fiscal management, with 3 years of administrative responsibility	Master's in Business or Public Administration
Director of Training and Recruitment	4 years of practice in rehabilitation or social work of which 2 years is in an agency serving the blind	Master's in a field related to Rehabilitation or Social Work
Director of Rehabilitation Counseling	4 years of practice in rehabilitation of which 2 years is in an agency serving the blind including 2 years of rehabilitation administration	Master's in Rehabilitation — related field
Director of Business Enterprises	4 years experience in business administration	Master's in Business Administration or Rehabilitation — related field
Assistant to the Commissioner for Public Affairs	4 years experience in health education or a related field	Master's in Education, Public Health, or Communications
Director of Rehabilitation Facilities and Special Programs	4 years of practice in rehabilitation of which 2 years is in an agency serving the blind including 2 years of experience in administration of rehabilitation centers and sheltered workshops	Master's in Rehabilitation — related field
Director of Social Services	4 years of practice in social work of which 2 years is in an agency serving the blind including 2 years in social services administration	Master's in Social Work — related field
Director of Health Services	4 years of practice in health services including 2 years in health services administration	Master's in Public Health or related field
Director of Financial and Medical Assistance Programs	4 years of experience in the administration of federal assistance programs	Master's in Business or Public Administration
Supervisor of Industries	4 years of practice in rehabilitation of which 2 years is in an agency serving the blind including 2 years of experience in the administration of sheltered workshops	Master's in Rehabilitation — related field
Supervisor of Home Teachers	4 years of experience in home teaching including 2 years of administrative responsibility	Master's in Home Teaching or related field
Supervisor of Children's Services	4 years of practice in social work with children of which 2 years is with blind children including 2 years in social service administration	Master's in Social Work — related field
Supervisor of Talking Books	4 years of experience in library services	Master's in Library Science
Supervisor of Fiscal Management	4 years of experience in fiscal management including 2 years of administrative responsibility	Bachelor's in Business Administration
Supervisor of Statistics	4 years of experience in a statistical unit including 2 years in administration of a statistical unit	Bachelor's in Statistics or Mathematics

[1]Such as Rehabilitation Counseling, Rehabilitation Administration, Social Work, Psychology, Guidance and Counseling, Occupational Therapy, or Special Education.

Salary for the Commissioner for the Blind was set at $14,000 in 1966 when the Commission was established. This amount was slightly less than the salary for the former position of Director of the Division of the Blind.

If Massachusetts wishes to remain competitive with private service agencies, other states, and the federal government, annual salaries for administrators at these two agencies should be increased to at least the following levels:

Commissioner	$25,000
Deputy Commissioner	$22,000
Assistant Commissioners	$18,000

State office positions carrying the title of *director* and the positions of Regional Rehabilitation Director should be rated at civil service grade 23 which ranges from $12,649.00 to $16,018.60 per year. State office positions designated as *supervisors* and positions of Area Rehabilitation Director should be rated at grade 21 ranging from $11,343.80 to $14,427.40 per year.

Although the salaries for the commissioners of several large departments are no greater than those recommended for the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, it should be noted that there exists a certain plateau in salary levels which must be achieved to recruit and retain qualified executives for public office regardless of differences in responsibility. In addition, salaries for top positions in Massachusetts are generally lower than those paid by neighboring states. For example, the salary for the position of Director of Vocational Rehabilitation in the state of New York is $22,778 and in the state of Connecticut, $23,060.

On the assumption that the inflation in wages will continue in the future as it has for the past 30 years, periodic raises should be given to maintain salaries of appointive positions at a level appropriate to their responsibility. The best method to accomplish this result would be to establish a comprehensive salary schedule for state appointive positions similar to the civil service schedule. Periodic adjustments to this schedule could be made by the General Court as is now done for classified service.

THE ROLE OF REHABILITATION FACILITIES

During fiscal year 1968, the Massachusetts Rehabilitation Commission contracted with about 30 rehabilitation facilities (rehabilitation centers and sheltered workshops) paying $684,349 for vocational rehabilitation services provided to its clients. Present estimates indicate a doubling of this amount in fiscal 1969. In 1968, the Massachusetts Commission for the Blind paid $275,000 to eight facilities for the same purpose. These facilities played a major role in the rehabilitation of handicapped persons by providing evaluation, adjustment, training, placement and followup services.

Because of a shortage of personnel experienced in the fields of facility administration and programming or in facility accounting, the Massachusetts Rehabilitation Commission has not been able to thoroughly evaluate the various rates charged by each of these facilities for the many different services offered. Nor has it been possible to make comprehensive examinations of professional qualifications of staff and quality of individual programs and services. Because it deals with a relatively small number of facilities and purchases only a limited range of services, the Massachusetts Commission for the Blind has not met with these difficulties. The Commissioner himself has been able to negotiate rates with all facilities used and also to examine their credentials.

As the Commonwealth increases its programs for disabled and disadvantaged persons, there will be an ever increasing use of rehabilitation facilities. Other sections of this report recommend the designation or establishment of at least one comprehensive sheltered workshop in each geographic service area; the designation or development of a disability evaluation center in each area which would provide rehabilitation services for the physically handicapped and chronically ill; and the designation or development of a work evaluation and adjustment center in each area to serve disadvantaged persons. It seems probable to estimate that by fiscal year 1976 the Commonwealth, through the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, will probably be spending at least $10 million to purchase services from rehabilitation facilities.

RATES FOR MEDICAL SERVICES

Under the provisions of 1968 legislation, the setting of rates for all medical services is the responsibility of a special rate setting commission located within the state Executive Office of Administration and Finance. This five member commission sets rates to be paid by all state departments and agencies for services rendered to their clients. The commission's responsibility includes rates for medical evaluations for rehabilitation which had heretofore been set by the individual departments. Licensing of hospitals and other medical facilities is not performed by the commission but instead by the Department of Public Health. This system of divided authority can potentially produce difficulties for the rate setting agency. If licensing standards are not well defined and strictly enforced, a wide variation in quality of services may result. The rate setting agency must then be given the authority to establish different rate categories to reflect the differences in quality of services. Because of this problem, the same agency should be authorized to certify programs and set rates for nonmedical rehabilitation services.

REHABILITATION FACILITIES BOARD

To perform these necessary rate setting and program certification functions for nonmedical rehabilitation services purchased by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, the Commonwealth should establish a Rehabilitation Facilities Board.

The Board's duties should also include formal designation of the area disability evaluation centers, the area sheltered workshops, and the area work evaluation and adjustment centers. As outlined in other sections of this report, one facility might be designated to perform all three responsibilities in a given area, or three separate facilities might be so designated.

Membership of the Board

The Rehabilitation Facilities Board should be composed of five members appointed by the Governor. Each member should have training and experience in a profession which is important to the operation of either a medically or vocationally oriented rehabilitation facility. Members should include: a certified public accountant or banker who regularly advises businesses on financial management problems; a doctor of medicine with experience in rehabilitation: a professional educator with experience in vocational-technical education; a health and welfare specialist such as a social worker, psychologist, or occupational therapist with experience in rehabilitation; and a rehabilitation specialist with training and experience in rehabilitation counseling or administration.

Members should be appointed to five year staggered terms. The chairman should be elected annually by the members. Each member should be paid $75.00 for each day spent in the performance of his duties. No member of the Board should be affiliated with or have a financial interest in any rehabilitation facility which provides services to clients of the Massachusetts Rehabilitation Commission or the Massachusetts Commission for the Blind. Nor should any member be a full time employee of the Commonwealth.

Certification of Programs and Services

Certification should be required for all nonmedical rehabilitation programs and services prior to their use by clients of public agencies. Certification should be renewed annually, according to regulations established by the Rehabilitation Facilities Board. The Board should use published standards of the National Association of Sheltered Workshops, the National Policy and Performance Council, Goodwill Industries, the National Commission for the Blind, and the Association of Rehabilitation Centers as guides for certification.

Staffing for the Board

The Rehabilitation Facilities Units of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should act as staff for the Rehabilitation Facilities Board. Staff duties should include analysis of rate and program proposals and financial statements submitted by the designated disability evaluation centers, sheltered workshops, work evaluation and adjustment centers, and other rehabilitation facilities serving clients of public agencies. The staff should provide technical assistance to these agencies in the preparation and revision of programs and in the establishment of proper accounting and financial management controls. Staff should also conduct periodic inspections of the programs and the financial records of the agencies. The staff should include personnel with professional training and experience in such fields as accounting and the administration of rehabilitation centers and sheltered workshops.

The Board should have its own budget and should be authorized to appoint an executive secretary. The executive secretary should be a recognized expert with professional training and experience in the field of rehabilitation facilities (both rehabilitation centers and sheltered workshops). His duties should include coordinating the presentation of staff reports from the two agencies in accordance with the desires of the Board. He should also act as the Board's technical advisor. The salary for this position should be sufficient to attract a person of outstanding competence. The position should not be subject to civil service laws.

RATES FOR REHABILITATION FACILITIES

Rates set by the Rehabilitation Facilitation Board should reflect the cost of services provided by the facility including all indirect costs and overhead. The present method of payment for services has little relation to actual costs. A fixed rate is set for each service offered by a particular facility, regardless of whether the public agency refers one client or 20 clients for that service. Since a rehabilitation facility, at present, has no way of predicting the number of referrals it will receive, it cannot accurately predict its revenue. Therefore, the facility may either suffer a large deficit or accrue large profits. This fiscal instability makes personnel recruitment and retention difficult and inhibits investment in the expansion or improvement of programs.

One approach to this problem would be for the Massachusetts Rehabilitation Commission or the Massachusetts Commission for the Blind to contractually guarantee a minimum number of client referrals to the facility. At first view, this proposal appears to be an attractive one. However, if the guarantee were not met, payments would be made for services not actually rendered. A significant question would then arise as to whether these payments of public monies were made to aid a private facility in violation of the Massachusetts Constitution since no services were received for the

payment. In addition, this procedure would probably raise significant political difficulties in attempting to get fiscal authorization for what on the surface appears to be a gift.

Another possibility might be to add to the contract for services, a certain percentage loss factor to cover any future decline in client referrals. The difficulty with this proposal is that it only redefines the problem. Setting the loss factor in advance depends on the expected client load which is the variable that cannot be accurately predicted. Selection of an arbitrary percentage could be either too high causing an unreasonable profit, or too low causing a substantial loss.

Retainer Rates

However, there are three alternative solutions to this problem. The first would be to put the whole facility or a portion of it on a retainer for the state. The amount paid as a retainer would include the facility's fixed costs such as rent, salaries, equipment, and utilities.

The retainer rate would reserve a particular program for the exclusive use of the public agency which could refer any number of clients up to the planned capacity. The retainer rate is presently used by the state Department of Commerce and Development for the services rendered by its advertising agency. This type of contract is similar to that of renting an office building to be used as needed over a long term period, whereby the landlord furnishes certain services in addition to providing the facility. Retainer rates should be established by the board only upon the joint request of the rehabilitation facility and the public agency.

Multiple Rates

For those programs in which a retainer rate is not desirable, a second alternative would be to establish a multiple rate structure. For purposes of illustration, a hypothetical example of multiple rates for a given program of services follows:

Base Rate	
(first 5 clients referred)	$1,000 per client
Marginal Rate	
(more than 5 clients)	$150 per client

The base rate should provide sufficient funds to cover that percentage of the facility's fixed costs (rent, salaries, equipment, and utilities) which are related to this particular program. In contrast to the present fixed rate per client, a multiple rate system can reflect varying degrees of efficiency of the program at different levels of client load. This "quantity discount" formulation is commonly used in private contracts for the sale of goods.

Actual Cost Rates

A third alternative would be to pay for actual cost of services performed. Each week or each month the facility would prorate its costs among all clients served. Under this method, payments would fluctuate each week depending on the total costs and the number of clients enrolled. This alternative would require that the facility institute a system of industrial cost accounting so that accurate charges to the public agencies could be made without a long delay.

Rates for rehabilitation services (like rates for public utilities) will never be uniform because of differences in each facility's cost of operation. For example, rents in the city of Boston are considerably higher than those in rural communities. In addition, some facilities may be fortunate enough to have received the gift of a building and need only to provide for insurance, taxes, and depreciation. Other facilities may have to provide for mortgage payments on their buildings.

Where practical, rates should be set for packages of evaluative or training services rather than for separate small components of service. In all three of the alternatives, it is assumed that any special or unusual services such as psychiatric evaluations would be paid for separately. Since all three methods would provide greater financial stability, rehabilitation facilities should be able to improve client services through more effective long range planning and improved personnel recruitment and retention.

INTERDEPARTMENTAL COORDINATION OF REHABILITATION SERVICES

REHABILITATION COORDINATING COUNCIL

In the Commonwealth today, a continuing need exists for effective coordination in the planning and provision of rehabilitation services. Programs related to rehabilitation are a part of the activities of many departments and agencies. These programs have developed as each agency sought to fulfill its mandate to serve a particular segment of our population.

At present the only mechanism for coordinating these programs is the Advisory Council to the Massachusetts Rehabilitation Commission. The council is composed of 14 members, five of whom are private citizens. The other nine members are the Commissioners of Public Welfare, Public Health, Education, Mental Health, Correction, and Probation, and the Director of Employment Security; the Chairman of the Industrial Accident Rehabilitation Board; and the Chairman of the Parole Board.

The statutory purpose of the Advisory Council is to advise the Commissioner of Rehabilitation on the "administration of the Commission and . . . the vocational rehabilitation of all handicapped persons, except the blind." G.L. c.6, § 75. No statutory mandate exists for all departments to coordinate their various rehabilitation activities.

As noted earlier, the Advisory Council should be split into two separate bodies performing quite different functions. The previously discussed State Rehabilitation Advisory Board should provide expanded citizen and consumer involvement with the rehabilitation programs. In addition, a state Rehabilitation Coordinating council should be established with the specific purpose of coordinating the activities of various departments so that rehabilitation services are provided for all disabled and disadvantaged persons in the most effective and efficient manner.

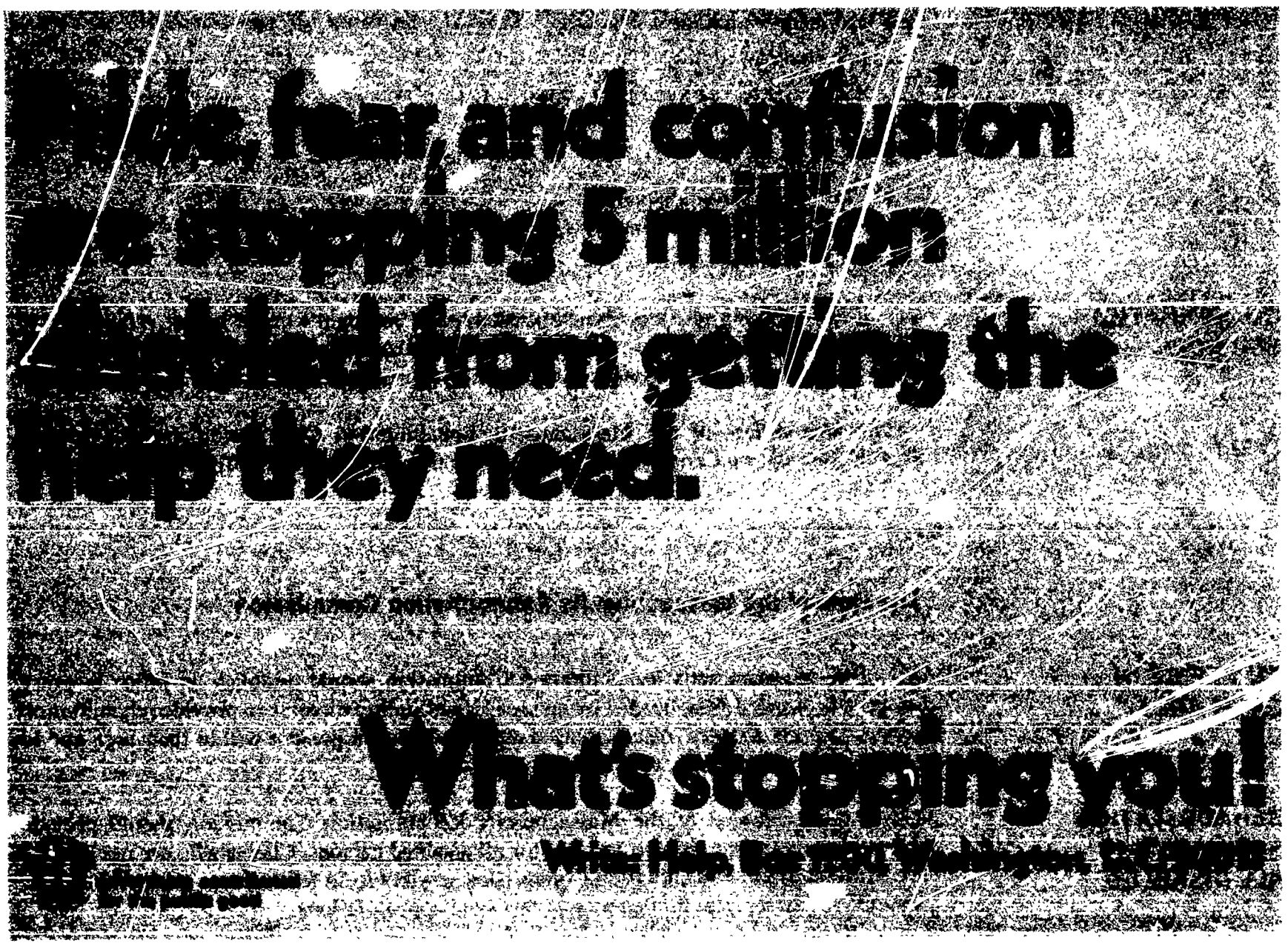
If the Rehabilitation Coordinating Council is to be effective in accomplishing its mandate, it should be composed of the commissioners or agency heads of all departments and agencies concerned with the provision of rehabilitation services. In addition to the nine public members of the present Advisory Council, the Commissioner for the Blind, the Chairman of the Youth Service Board, and the Commissioner of Administration should be represented. The Commissioner of Rehabilitation should serve as chairman of the council and the Commissioner for the Blind should serve as the vice-chairman.

The Council should be concerned with improving the coordination and effectiveness of all public programs for the rehabilitation of handicapped persons. However, particular emphasis should be placed on the following:

- Increasing the multidepartmental use of existing and newly constructed facilities.
- Developing new interagency programs to serve handicapped persons under which staff salaries and facilities of various departments will be matched by federal vocational rehabilitation monies.
- Instituting interdepartmental training programs for public and voluntary agency personnel concerned with the problems of disabled and disadvantaged persons.

NECESSARY FIRST STEPS

This section of the report has discussed only the administration of rehabilitation services. The following section will focus on the development and delivery of rehabilitation services within a geographic service area. Implementation of new and improved programs and services as described in this report will not be possible unless a sufficient number of administrators possessing the necessary training and experience is available. Greatly increased salaries and improved inservice training programs are necessary first steps towards retaining and attracting top quality administrators who can plan and provide the services needed to help all the handicapped.



PROVIDING COMPREHENSIVE REHABILITATION SERVICES IN THE COMMUNITY

RECOMMENDATIONS

Comprehensive and Coordinated Services

COMPREHENSIVE SERVICES

19. Comprehensive area rehabilitation programs should be organized in each geographic service area to provide rehabilitation services to all disabled, disadvantaged and handicapped persons at the local community level.

SERVICE ELEMENTS

20. A comprehensive area rehabilitation program should include at least the following service elements:

- Prevention, casefinding and outreach
- Vocational evaluation
- Physical and mental restoration
- Personal adjustment training (prevocational)
- Vocational training
- Vocational-technical education
- Undergraduate and professional education
- Transitional and extended sheltered employment
- Vocational placement and followup
- Day care for adults
- Personal counseling
- Social and recreational programs
- Special housing
- Transportation
- Homebound employment
- Homemaking, attendant and other services in the home
- Consultation to agencies

COORDINATED SERVICES

21. Close working relations should be established among the major health, rehabilitation and social service agencies in each area to insure that potential clients are identified and referred, to close gaps in services and to minimize program duplication.

The area offices of the Massachusetts Rehabilitation Commission and the Mental Health-Retardation Centers should stimulate and promote such coordination.

The Role of the Massachusetts Rehabilitation Commission

AN OFFICE IN EACH AREA

22. The Massachusetts Rehabilitation Commission should establish an office in every geographic service area, headed by an area rehabilitation director to provide rehabilitation services for all disabled, disadvantaged and handicapped persons within their area and to develop comprehensive area rehabilitation programs.

REHABILITATION SERVICES FOR ALL DISABLED

23. Area personnel of the Massachusetts Rehabilitation Commission should provide comprehensive rehabilitation services for all disabled persons. Clients who are not eligible for Massachusetts Rehabilitation Commission services from federal/state matching monies should receive services funded by separate state appropriations.

DEVELOPING COMPREHENSIVE SERVICES

24. Contractual arrangements with public and voluntary rehabilitation agencies should be initiated by the area rehabilitation director in consultation with his area rehabilitation board to stimulate the development of comprehensive rehabilitation services and to enhance coordination among programs.

SERVICE PRIORITIES

25. Priorities for rehabilitation services among areas should be determined by the Massachusetts Rehabilitation Commission in consultation with the state Rehabilitation Advisory Board.

Priorities for rehabilitation services within an area should be established by the area rehabilitation director in consultation with the area rehabilitation advisory board on the basis of their knowledge of local needs and resources.

The Role of the Massachusetts Commission for the Blind

DECENTRALIZATION OF SERVICES

26. The Massachusetts Commission for the Blind should further decentralize their services by assigning personnel to each area office of the Massachusetts Rehabilitation Commission on a liaison basis to improve casefinding and to provide services for blind persons living in each area.

Major Service Components of Area Rehabilitation Programs

[Although the following three recommendations are found in appropriate sections elsewhere in the report, they are included here in order to provide a more complete picture of area programs.]

EARLY CASEFINDING

Early casefinding and prevention should be carried out in each area by all agencies and practitioners who work with disabled persons such as schools, hospitals, courts, physicians and clergymen, as discussed in the section on Early Casefinding and Prevention.

EVALUATION AND TREATMENT

Vocational evaluations and certain restorative services should be provided in each area at appropriate facilities, as discussed in the section on Vocational Evaluations.

TRANSITIONAL AND EXTENDED SHELTERED WORKSHOPS AND HOMEBOUND EMPLOYMENT

Transitional and extended sheltered workshops services and homebound employment services should be available in each area as discussed in the section on Education, Training and Sheltered Employment.

Special Services

DAY ACTIVITIES

27. A program of day activities for adults who are too severely disabled to utilize transitional or extended workshops should be established in each rehabilitation service area. Day activities should be provided by the area sheltered workshops as well as other public and private agencies. Day activities should be physically separate from the workshop, but common administrative and program staff should be utilized.

ITINERANT TEACHERS

28. The Bureau of Special Education should provide itinerant teachers to public schools which have deaf pupils who require special teaching techniques in some subjects.

SERVICES FOR THE HOMEBOUND AND OTHER DISABLED PERSONS

29. Nursing, homemaking, attendant, and other in home services should be made available to disabled persons to support their self sufficiently in their home, to prepare them to get to work and to utilize community services.

Medical and psychological services should be made available on a home visit basis to persons who are unable to get to community agencies.

Special Types of Referral

COMMUNITY SERVICES FOR FORMER RESIDENTS OF INSTITUTIONS

30. Clients of state hospitals, state schools, chronic disease hospitals and correctional institutions, who may require continuing vocational rehabilitation services following their discharge from the institution should be referred to the area office of the Massachusetts Rehabilitation Commission or the community mental health-retardation centers as early as possible before their discharge from the institution, to insure that they will receive appropriate and continuing services in the community.

ACCESS TO SERVICES IN ALL AREAS

31. Clients should be referred to services in other areas if the services they require are not available locally or, if feasible, when they prefer to utilize services in other areas of the Commonwealth.

ELEMENTS OF THE REHABILITATION PROCESS

UNIQUE STRENGTHS OF THE PUBLIC REHABILITATION PROGRAM

Considerable attention is now being paid to the unique strengths of the public rehabilitation program in providing services to handicapped persons including:

- Developing an individualized plan for each client requiring rehabilitation services.
- Keeping the objective of employability or independent life functioning of each handicapped client foremost.
- Maintaining fiscal flexibility in the provision of client services allowing required services to be purchased from public and private resources best able to contribute towards a client's rehabilitation goal.

These strengths stand out in contrast to the fragmented organization of most other health, social service and manpower programs. Frequently, health and welfare agencies view their clients through the lenses of the agency's mandate to provide specific services or from the perspective of the professional training and background of their personnel. A client's initial problem may be one aspect of a larger circle of problems which might include lack of income, lack of job skills, inadequate education, or general health problems. Clients may get help with those services which a particular agency is competent to provide. They may get little else.

Other types of services require mass programming or grouping people on the basis of services they receive. In the past, federally supported manpower programs grouped disadvantaged, unskilled or underskilled persons into a variety of vocational training and work adjustment programs. At times, the individual vocational needs of persons are not taken into account. In addition, other types of social and health services to assist clients in adjusting to the work world may be lacking. Vocational rehabilitation programs bring to bear a coordinated array of resources to help disabled, disadvantaged and handicapped persons achieve dignified stations in life. With all of the constructive implications this entails for the family and for the community, the vocational rehabilitation program is looked to as a promising model for serving the total needs of disabled persons. The responsiveness to special needs of individual clients may considerably enhance the prospects of successful rehabilitation.

Strengths of the public rehabilitation approach are not automatically translated into services for handicapped persons by stating them as objectives. An individualized plan for each client can, and frequently does, take inordinate amounts of time to prepare and carry out. Long waiting periods for establishing eligibility and for actually delivering these services can, and frequently does, thwart the rehabilitation process. Also, because rehabilitation manpower and client service funds may be limited in a particular locality at a particular time, many potential clients go unserved.

COMPREHENSIVE SERVICES

Many agencies in the Commonwealth evaluate and train handicapped persons for work and help them to find jobs. However, some of these services are fragmented, and serve only clients with certain kinds of disabilities or levels of functioning. In addition, facilities are clustered in and near the major population centers of the state.

To be able to work, many disabled persons need a variety of services such as vocational evaluation, personal adjustment services, vocational training, and placement and followup. Many clients will not require all of these services. Yet, effective rehabilitation can only take place if the handicapped person's needs are viewed as those of a total human being who must receive services which deal with his present symptoms as well as with related problems.

Many failures in rehabilitation can be traced to the atrophy of social and psychological functioning as well as of physical functions. Potential for employability is multiply effected. Initial shock is followed by anxiety after an accident, operation or the onset of serious illness. Will recovery be complete? How long will it take? If a chronic disability results, how will it effect the ability to work? Is the family discouraged and upset? Will the disability effect their relations? Discouragement, impatience and fear can undo much of the progress in overcoming physical and mental disabilities. For this reason, social, psychological and physical impairments must be seen as closely interrelated and dealt with on that basis.

Present services are frequently so fragmented that following physical or mental restoration, there is no continuity leading to services which provide personal adjustment, self care skills, a temporary income and other types of preparation and support for vocational training. A middle aged man just released from the hospital after a stroke may need speech therapy; a retarded teenager no longer attending school may require training in specific work skills; a stoma patient may need post operative training in self care; or a housewife completing therapy at a mental health clinic may need the support of a social group. Each person received necessary initial services but now needs referrals to other agencies. Many of them do not know where to turn. Area rehabilitation programs should be so organized that services are visible and accessible to disabled, disadvantaged and handicapped persons near their homes to fulfill their total rehabilitation needs.

SERVICE ELEMENTS

To provide a comprehensive rehabilitation program, each geographic service area should have the following minimum services available. Extension of services to new clients, particularly those with multiple problems, may necessitate changes and additions to this list in the future:

- Prevention, casefinding and outreach
- Vocational evaluation
- Physical and mental restoration
- Personal and adjustment training (prevocational)
- Vocational training
- Vocational-technical education
- Undergraduate and professional education
- Transitional and extended sheltered employment
- Vocational placement and followup
- Day care for adults
- Personal counseling
- Social and recreational programs
- Special housing
- Transportation
- Homebound employment
- Homemaking, attendant and other services in the home
- Consultation to agencies

Mentally and physically disabled persons require a wide range of services. Some persons may need a single service, others many services, simultaneously or in sequence. The timely discovery, evaluation and treatment of a disibility may determine whether the disability is reversible. For some handicapped persons vocational training must be preceded by personal adjustment services, such as counseling, the use of prosthetic devices, or post surgical training in self care.

COORDINATED SERVICES

When the responsibility for a client is divided among a number of different agencies, there must be sufficient coordination to allow clients to move from one system to another without a discontinuation of services. When persons in need are either not being served or not being served adequately, critics of the system call for coordination. What is usually meant is coordination among agencies or service units. Frequently, the client for whom the coordination is intended is overlooked. Effective coordination on behalf of individual clients stressing responsiveness to their individual needs should be the object of all coordination. The traditional approach of the Massachusetts Rehabilitation Commission for providing client services through fee for service and contractual arrangements should be expanded to take advantage of the capabilities of existing service resources. Federal funds are becoming increasingly available under the public rehabilitation programs and should be used to strengthen the major services in each area. The goals of the public rehabilitation program can best be served by providing incentives for public and private agencies in each area to participate in the expansion and strengthening of comprehensive programs. (See Chart 1)

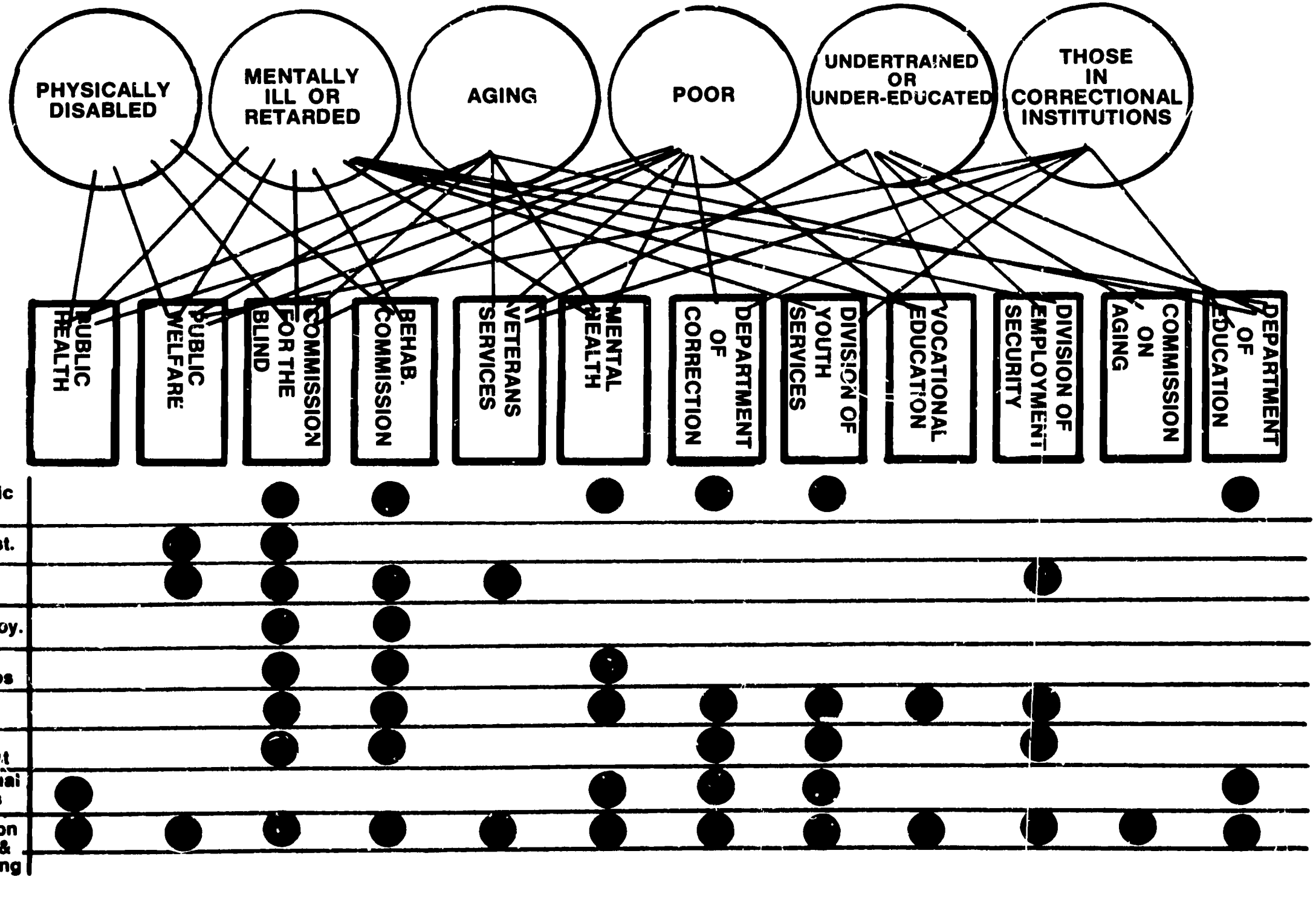
Too often, the easy solution to the provision of health, welfare and rehabilitation services is to erect a new building or to combine a variety of specialized services under the roof of a single facility. In some instances, this has been a useful device for bringing different programs into closer proximity to each other. However, considerable evidence indicates that merely bringing services into closer proximity with each other does not alone guarantee improved functioning. Moreover, the specialization of services frequently requires different types of facilities and equipment.

When these considerations are added to the swelling cost of constructing new buildings, the conclusion is reached that new facilities, especially public facilities, should be built only when new construction is essential and the envisioned program does not duplicate the programs provided in existing facilities. More consideration should be given to expanding and coordinating existing programs.

An important step toward the provision of multiservice human service programs can take place with the establishment of area rehabilitation programs stressing the coordination of services for the handicapped in each geographic service area. Multiservice programs do not necessarily infer the need to establish a single facility for everything. Every public and private agency, meeting required standards and presently providing any of the required rehabilitation services might expand their functions to provide such services for disabled persons and should be included in an area's comprehensive rehabilitation program. Coordination is needed on the area level to limit duplication of services, to insure that the full range of services are provided, to maintain high standards, and to insure accessibility of services.

Chart 1

STATE AGENCIES PROVIDING SERVICES TO POTENTIALLY REHABILITABLE PERSONS*



This chart illustrates how many different state agencies have f
various rehabilitation services for persons with a potential for bein
Prepared by: Office of Program Planning and Coordination.
Massachusetts Department of Administration and

AREA OFFICES OF THE MASSACHUSETTS REHABILITATION COMMISSION

Physically disabled, mentally ill, mentally retarded, chronically ill, and socially disadvantaged persons need a place in their community to which they can turn for help with work problems, housing and transportation needs or other major life activities.

Although services need not be provided by a single agency, services should be coordinated by one agency to insure that an initial assessment of the client's disability is undertaken and that the client is referred to appropriate agencies for services and receives followup. Coordination should be the responsibility of the Massachusetts Rehabilitation Commission, working in conjunction with agencies capable of identifying potential clients and able to provide rehabilitation services.

An office of the Massachusetts Rehabilitation Commission, under the direction of an area rehabilitation director, should be established in each geographic service area. This area office should assume responsibility for casefinding, vocational evaluation, training, placement and followup for all disabled, disadvantaged and handicapped persons who are not receiving such services from other agencies by referring them to appropriate resources.

Program Functions

Area offices of the Massachusetts Rehabilitation Commission should expand their present services to include the following responsibilities:

- Serve as a fixed point of referral for all physically and mentally disabled, chronically ill and disadvantaged persons in each geographic service area.
- Conduct intake and central registry of all referred persons.
- Provide preliminary and/or comprehensive vocational evaluations for all persons requesting vocational services regardless of the nature of the disability, the existence of multiple handicaps or the preliminary prognosis for ultimate vocational rehabilitation.
- Determine the eligibility of clients for Massachusetts Rehabilitation Commission services or investigate other potential funding sources.
- Refer clients to appropriate services within the area or in other areas of the state, following their evaluation.
- Provide and stimulate the development of supportive services such as transportation and housing.
- Followup all referrals and retain responsibility for the client throughout the entire process and in the future when he may again require help.
- Maintain formal working relations with all rehabilitation agencies in the area to facilitate referrals to and from the area office, insuring clients of continuity of care.

HOW WILL HANDICAPPED PERSONS RECEIVE REHABILITATION SERVICES IN THEIR COMMUNITIES?

Innovative use of the staff of each area office, development of centralized evaluations, coordination of rehabilitation services, serving all clients regardless of source of financing and more intensive followup procedures each will contribute to making rehabilitation services more effective and more readily available locally. Chart 1 shows how handicapped persons will receive services in their communities and the following material describes the process.

Finding the Disabled

Most of the disabled are known to one agency or another. They are students in schools, patients in private treatment or in hospitals, clients of mental health clinics, members of recreational centers, or job applicants in employment offices. These and other sources are potential alerting stations for persons requiring vocational rehabilitation services. In addition to fulfilling their specific responsibility for the client, the staff of alerting stations should be sufficiently informed to bring clients into contact with rehabilitation agencies. Some of the counselors assigned to area offices of the Massachusetts Rehabilitation Commission should not be working out of the area office as has traditionally been the case. Instead counselors should be located at disability evaluation centers, mental health-retardation centers, sheltered workshops, schools and other major agencies located in the area.

A vital key to improved case finding rests in the assignment of staff from the area office to alerting stations on a full or part time basis. Liaison consultants should sensitize alerting station staff to case finding through consultation and help expedite client referrals to appropriate agencies by providing necessary administrative links.

Intake and central registry of potential clients can take place at a school, a general hospital or a court clinic as well as at an area rehabilitation office, provided that adequate reporting systems to the area office are developed. Determining eligibility for specific sources of financing can be accomplished by counselors assigned to alerting stations and evaluation centers.

Lifetime Registry for Rehabilitation Services

Often a client who has received services requires additional help at a future time. At that time, intake, evaluation and other procedures are sometimes unecessarily repeated. Some information must certainly be update, but only on a selected basis.

Lifetime registry is tantamount to a permanent case file containing a client's personal data, evaluations, record of services received, placements and followup. This information should be utilized by the Massachusetts Rehabilitation Commission and the mental health-retardation centers as a highly confidential record which ficilitates and improves future services.

CHART 2
HOW HANDICAPPED PERSONS SHOULD RECEIVE REHABILITATION SERVICES IN THEIR COMMUNITIES

Disabled and disadvantaged persons living in a geographic service area • • • are found • • • • registered for services • • • • their work potential is determin

ALERTING STATIONS

- Schools
- Hospitals
- Clergymen
- Social Service Agencies
- Physicians
- Courts
- Mental Health Clinics and Centers
- Recreational Centers
- Employment Office
- Draft Boards
- Area Offices of the Massachusetts Rehabilitation Commission

AREA OFFICE OF THE MASSACHUSETTS REHABILITATION COMMISSION

Physically Disabled	at the	Area Disability Evaluation Center	→	AT: Area Disability Evaluation Center BY: Evaluation Team from Area Disability Evaluation Center and Massachusetts Rehabilitation Commission
Mentally Disabled	at the	Area Mental Health-Retardation Center	→	AT: Area Mental Health — Retardation Center BY: Evaluation Team from Area Mental Health — Retardation Center and Massachusetts Rehabilitation Commission
Socially Disadvantaged	at the	Area Sheltered Workshop	→	AT: Area Sheltered Workshop BY: Workshop Evaluation Team

needed services are provided • they are appropriately placed • and receive followup services.

- Physical and Mental Restoration
- Personal Adjustment Training
- Vocational Training
- On the Job Training
- Work Study
- Vocational and Technical Training
- Undergraduate and Professional Education
- Transitional Sheltered Employment
- Day Care for Adults
- Personal Counseling
- Social and Recreational Programs
- Special Housing
- Transportation
- Homebound Employment
- Homemaking, Attendant, and Other Inhome Services
- Other Services

Competitive Employment

- Extended Sheltered Employment
- Homebound Employment
- Day Activities
- Homemaker
- Other Placement

- Review of placement with client, family and employer
- Further services as needed:
  Special Housing
  Transportation
  Social Clubs
  Counseling
  Other Services

★ Financing for services for the socially disadvantaged will be provided by federal programs such as the Social Security Act or Manpower Development & Training Act rather than from Vocational Rehabilitation monies.

All information required for central registration can be gathered by counselors at the alerting stations and forwarded to the area rehabilitation office or the mental health-retardation center. Most clients need never visit the area office in order to receive services.

Clients should be informed that their records are being retained permanently at the area offices and understand the use to which the permanent record will be put.

Determining Work Potential and Developing a Vocational Plan

At the present time, counselors of the Massachusetts Rehabilitation Commission send clients who may be eligible for the vocational rehabilitation program to various professionals for medical, psychological and other appropriate evaluations. When the evaluations are completed and the reports returned the counselor develops a rehabilitation plan and initiates the process of treatment and/or training. Major problems with this procedure are the length of time from initial referral to the beginning of a program of services and the fragmented nature of the evaluation.

To reduce the time delay and to provide team evaluations, certain agencies should be designated in each area to provide comprehensive evaluations as follows:

- For those with primarily physical disabilities, area disability evaluation centers such as hospitals or rehabilitation centers should be designated.
- For those with primarily mental disabilities, area mental health-retardation centers or other evaluation resources utilized by area mental health-retardation center programs under the Community Mental Health Act of 1966 should be designated.
- For those with primarily undifferentiated vocational or social handicaps, designated area workshops or other work evaluation or adjustment centers to be activated under the provisions of Section 15 of the Vocational Rehabilitation Act as amended in 1968, should be used.

A rehabilitation counselor from the Massachusetts Rehabilitation Commission or, where appropriate from the Massachusetts Commission for the Blind, should be a member of the evaluation team at each of the above centers. This staff member should participate substantively in the team evaluation and should act upon the recommendations of the evaluating team. This counselor should then assume responsibility for the client and should oversee his progress throughout the entire rehabilitation process. If possible, the counselor's office should be in the same building or in a building adjoining the evaluation centers to facilitate team evaluations and to minimize travel expenses and travel time. If the mental health center and the disability evaluation center or the area workshop are near each other, counselors working with both centers can utilize joint office space. If the centers are separated, the Massachusetts Rehabilitation Commission and the Commission for the Blind should have office space at each location. This recommendation does not mean that new buildings to house the state's rehabilitation services should be constructed, but rather that such services should be accommodated within existing structures. However, if new mental health centers, workshops, or disability evaluation centers are constructed, provision for state rehabilitation personnel should be made.

Counselors working at evaluation centers should have sufficient administrative and clerical personnel to perform reception, clerical and record keeping functions.

Referrals from alerting stations should come directly to the appropriate evaluation center and should receive further processing by the counselor(s) working there. Clients for whom little can be done on the basis of a comprehensive evaluation should be reevaluated at least every three years.

Providing Needed Services

Following evaluations, a rehabilitation plan should be developed utilizing the full array of services available in each area. When feasible, physically disabled, mentally disabled and socially disadvantaged clients should use area resources in common. Success in providing clients with needed services rests upon the extent to which comprehensive services are available.

The financing of services for the socially disadvantaged beyond vocational evaluation cannot, at this time, be provided from federal vocational rehabilitation monies. Financing for these services can be provided by other federal programs such as the Social Security Act or Manpower and Training Act.

Following vocational evaluations, counselors for the Massachusetts Rehabilitation Commission should refer such clients to appropriate programs and follow up such referrals.

Contractual arrangements and close working relations between the area offices of the Massachusetts Rehabilitation Commission, the community mental health-retardation centers and all rehabilitation resources in the area are the best means of expanding services and of facilitating referrals.

Following evaluations, counselors should refer clients to appropriate rehabilitation services. Counselors should also refer clients to the area transportation coordinator and the housing coordinator for assistance, if needed.

Clients who need personal counseling, recreation or remedial education should receive these services directly from workshop staff through referral by the counselor having overall responsibility for the client.

Appropriate Placement and Followup

A client may be placed in competitive or sheltered employment by the agency responsible for his training or his education. However, placement is still the responsibility of the rehabilitation counselor supervising the case and all placements should be cleared with him.

A similar procedure should take place for followups. Many agencies which place clients will conduct their own follow up. Followup should also be done by counselors, placing clients from prisons, state hospitals, schools for the retarded and other institutions. The success of a placement should be followed for one year. Counselors responsible for the case should provide followup directly if it is not being done by other agencies and should make additional services available to the client if needed.

REHABILITATION SERVICES FOR ALL DISABLED

The area staff of the Massachusetts Rehabilitation Commission and assigned staff from the Commission for the Blind should actively pursue the roles of client expeditors. Local staff persons should view themselves as the advocates of all disabled persons residing in the area. In many instances rehabilitation counselors performed this role for persons eligible for the public program. In the future, this advocacy role should be performed for all disabled persons, whether or not they are eligible for services funded by the federal rehabilitation program. Area rehabilitation programs should provide pathways for the meshing of appropriate services for disabled persons regardless of the sources of funding for such services. Coordinating services for the disabled will be carried out in name only unless advocacy responsibilities are seriously undertaken.

With the broadening of federal eligibility criteria in the 1965 and 1968 amendments to the Vocational Rehabilitation Act, particularly to include the disadvantaged, an increasing number of persons will become eligible for services with federal funding. But some severely disabled persons are still not covered by the federal program. Additional state funds should be made available to the Massachusetts Rehabilitation Commission to purchase services such as day activities, extended employment and homebound employment, where it is not possible to use state-federal matching monies.

DEVELOPING COMPREHENSIVE SERVICES

Area rehabilitation directors and the area rehabilitation advisory boards should assume the responsibility for coordinating rehabilitation services in each area. This does not imply administrative or policy making control over participating agencies. Rather, coordination is accomplished when the area rehabilitation director gets public and private agencies to provide needed services from their own resources, or enters into contracts with these agencies to purchase needed services.

Coordination is needed on the area level to limit duplication of services, to insure that the full range of services is provided, that they are accessible and that high standards are maintained. To accomplish this, area rehabilitation advisory boards and area rehabilitation staff should be thoroughly familiar with the types of rehabilitation services needed by disabled persons living in their area and the resources which are available to them. One of the major responsibilities of area staff should be to help caregivers in their area to understand the role each of them should play in building a comprehensive area program. This understanding is particularly important since the coordination which must be achieved depends largely upon the voluntary cooperation of these agencies. (See Chart 3)

CONTRACT AND FEE FOR SERVICE ARRANGEMENT

Comprehensive rehabilitation services will be enhanced if public and voluntary agencies are sufficiently flexible to expand or to curtail certain rehabilitation services on the basis of current needs and long range plans.

Area rehabilitation directors, in consultation with area rehabilitation advisory boards, should enter into contract and fee for service arrangements with public and voluntary agencies as a means of stimulating the provision of the most necessary services. Approval for funding of these contracts should rest with the Commissioner of Massachusetts Rehabilitation.

SERVICE PRIORITIES

Two levels of rehabilitation service priorities exist in the Commonwealth: the first exists among areas, the second within areas. Where areas have a high priority (great need and relatively few resources), the Massachusetts Rehabilitation Commission should plan to expand and establish new programs, mainly through the purchase of services from agencies in the area. High priority areas should receive relatively more funds than low priority areas.

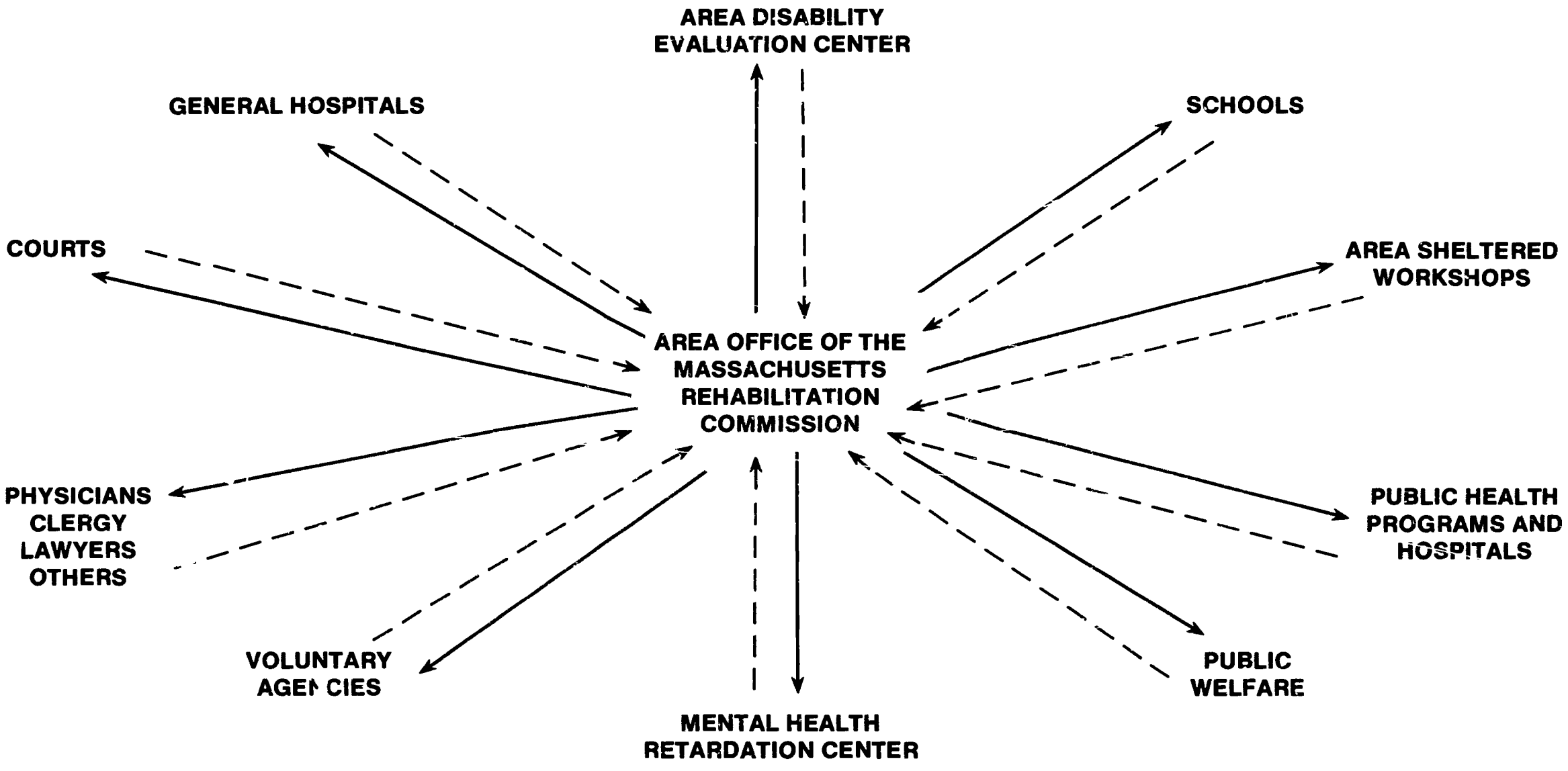
Specific services purchased within an area should be based on another priority level, that which exists within any given area. Priorities should be recommended by the area rehabilitation director and the area rehabilitation advisory board, based on their intimate knowledge of area resources and service requirements.

DECENTRALIZATION OF SERVICES BY THE MASSACHUSETTS COMMISSION FOR THE BLIND

Presently, staff of the Massachusetts Commission for the Blind who work with agencies and clients in other parts of the state, work directly out of their homes and come to the central office in Boston for conferences and to complete administrative tasks. Services of the Massachusetts Commission for the Blind should be more readily available in every area of the Commonwealth.

Separate area offices for the Commission for the Blind do not appear to be justified in view of the client load. Rather, rehabilitation counselors and social workers of the Massachusetts Commission for the Blind should work out of the area office of the Massachusetts Rehabilitation Commission.

Chart 3
PROPOSED RELATIONSHIP OF THE MASSACHUSETTS REHABILITATION COMMISSION TO AREA HEALTH AND WELFARE AGENCIES*



Based on fourfold increase of staff of the Massachusetts Rehabilitation Commission by 1976.

Liaison staff from the area office of the Massachusetts Rehabilitation Commission working in local health and welfare agencies on a full time or part time basis.

Client referral to Massachusetts Rehabilitation Commission area office from local agencies and alerting stations.

* The Massachusetts Commission for the Blind will make liaison counselors available to the area office of the Massachusetts Rehabilitation Commission and local agencies when needed.

This arrangement will enable them to perform their liaison functions with local agencies, to participate in team evaluations and to refer blind clients to social and rehabilitation services.

In some areas, part time staff will be sufficient to carry out necessary responsibilities. Arrangements should be made between the two agencies for the staff of the Commission for the Blind to use equipment, telephone, and secretarial help as needed.

DAY ACTIVITIES

Some persons are so severely disabled that they may not be capable of any work. These persons need social activities and training in self care to improve their functioning and to relieve their families of some of the responsibility for their care.

To meet the requirements of this group, day activity programs should be instituted in each area by the area sheltered workshop as well as by other agencies. For the most part, day activity programs should be physically separate from the rest of the workshop programs. When feasible, common recreational and dining areas should be used. Programs for all clients using workshops should be conducted under centralized administration utilizing certain staff members in common.

Fees for day activity programs should be paid by the Department of Mental Health, Public Health, and Public Welfare and voluntary agencies such as associations for retarded children and united cerebral palsy associations and other public and private agencies whose clients require day care services. Fees from individuals or their families should also be utilized.

ITINERANT TEACHERS

Students with hearing impairments require the services of itinerant teachers utilizing special educational methods and techniques. Itinerant teachers can provide special tutoring to students as well as consultation to teachers and school administrators.

Massachusetts has no special high school for pupils with impaired hearing. Each year, about 50 deaf students begin to attend public or private high schools in their respective communities integrated with normal hearing children. Many of the deaf students drop out during their first or second years, for some of the following reasons:

- There is no one available to introduce new terminology or new concepts and to prepare deaf students for subject matter to be taught.
- There is no one available who is able to communicate with deaf students and who is aware of unique problems.
- There is often a lack of sufficient interest and understanding on the part of school administrators and teachers in keeping hearing impaired students a part of the overall school experience by giving them special information and by providing them with proper seating, lighting and teaching techniques to help insure their participation.

Itinerant teachers should be employed by the Bureau of Special Education in the Department of Education. The General Court in adopting Chapter 761, Acts of 1967, already provided a mandate for the Department of Education, as follows: "In any . . . school district in which reside any children with impaired hearing, the department shall, in cooperation with the school committee, establish day classes, resource teacher programs or itinerant teacher programs . ."

The Department of Education has authorized positions for these itinerant teachers. Legislation is scheduled to be introduced at the 1969 session to correct inadequacies of salary and tenure which may be responsible for leaving these positions unfilled.

It may be desirable for the Massachusetts Rehabilitation Commission to provide a limited number of itinerant teachers on an interim basis (for two or three years) until the programs of the Bureau of Special Education are in full operation. However, this is a complicated procedure requiring the Massachusetts Rehabilitation Commission to accept each individual student as a client before providing services.

SUPPORTIVE SERVICES FOR THE HOMEBOUND AND OTHER DISABLED PERSONS

In addition to needing work, homebound persons often need other types of help such as nursing, homemaking, attendant services, meals on wheels and personal counseling. These services should be provided to homebound persons on a visiting basis.

Area rehabilitation directors should centralize requests for homebound services and develop area resources and contractual arrangements to fulfill the demands.

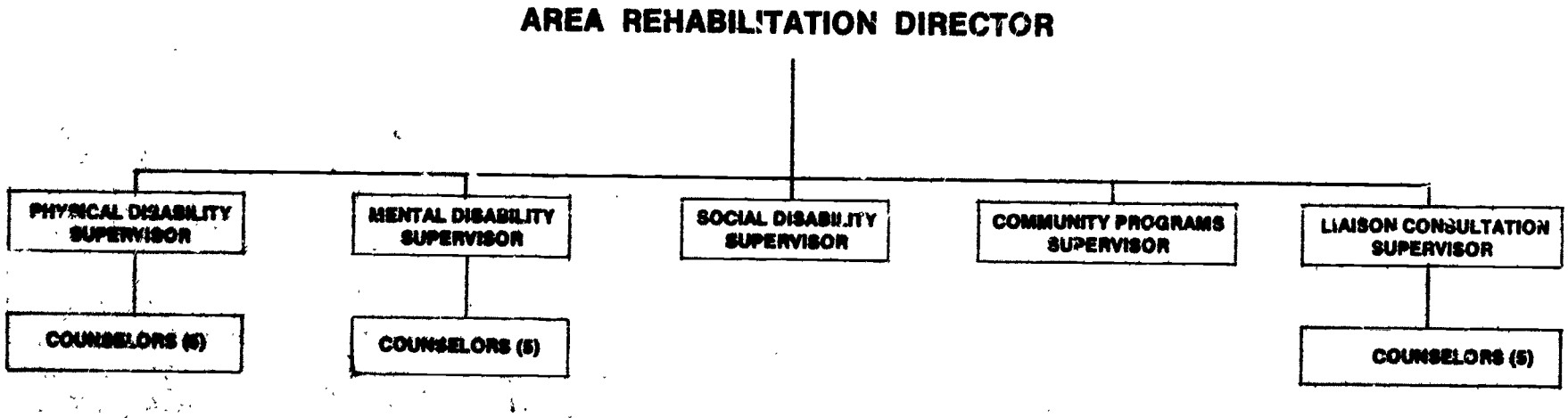
Homebound clients receiving work through sheltered workshops should secure supportive services directly from the workshop, when staff permits, or on a fee for service arrangement with other appropriate agencies. Funds for supportive services should be allocated by the state through the Massachusetts Rehabilitation Commission.

COMMUNITY SERVICES FOR FORMER RESIDENTS OF INSTITUTIONS

Often, the transition from an institutional setting to living in the community is difficult for the individual and requires support on a number of levels. Correctional institutions, state schools for the retarded, state hospitals and other residential centers should prepare their clients for community living over a period of time before clients are ready to leave the institution. An important link between the institution and the community should be established for those clients

Chart 4

PROPOSED ORGANIZATION CHART FOR PROFESSIONAL POSITIONS IN AN AREA OFFICE OF THE MASSACHUSETTS REHABILITATION COMMISSION*



* Considerable variation is anticipated in staffing patterns from one area to the next depending upon population and area resources. In small offices, supervisors should carry a caseload.

requiring continuing vocational rehabilitation services by referring them to the area office of the Massachusetts Rehabilitation Commission or mental health-retardation center as early as possible before their discharge. These agencies can then assume appropriate responsibility for the client's vocational adjustment in the community on an ongoing basis.

ACCESS TO SERVICES IN ALL AREAS

When comprehensive rehabilitation programs are developed in every area, most persons should be able to receive vocational rehabilitation services close to where they live. However, this may take ten or more years. In addition, providing services in every area for certain clients such as those with severe burns, cancer or spinal cord injuries may not be justified. Instead these should be operated on a regional or statewide basis.

Clients should be referred to appropriate services in any geographic service area of the state. Whenever possible, client preference as to where he would like to receive services should also be taken into consideration. Clients who wish to be near their families or to receive services from professionals they already know, should be accommodated when possible, even though similar services are available in their own area.

EARLY CASEFINDING AND THE PREVENTION OF HANDICAPS

RECOMMENDATIONS

IMPROVING SCREENING TECHNIQUES

32. A Health Screening Procedures Committee should be established under the auspices of the Massachusetts Department of Public Health to evaluate new techniques for screening physical disabilities at all ages and to decide on statewide implementation of the most appropriate techniques.

COMMISSION ON SCHOOL HEALTH EXAMINATIONS

33. School health services and policies should be thoroughly reviewed and recommendations for new personnel standards and procedures to replace the present *Regulations for Physical Examination of School Children in Massachusetts* should be made by a special commission of experts appointed by the Governor.

INSERVICE TRAINING FOR SCHOOL PERSONNEL

34. The Bureau of Special Education of the Massachusetts Department of Education should provide inservice training concerning problems of the handicapped child to school personnel responsible for special pupil services such as guidance counselors, adjustment counselors, nurses, and social workers.

ALERTING STATIONS

35. All local agencies and practitioners coming into contact with disabled persons such as schools, hospitals, mental health clinics, courts, physicians, counselors and clergymen should serve as alerting stations by providing the following functions:

- Becoming sensitized to the special needs of handicapped persons.
- Discovering persons with potential vocational handicaps.
- Alerting appropriate rehabilitation agencies or personnel about these handicapped persons.

LIAISON CONSULTANTS

36. A new category of personnel, liaison consultants, from the Massachusetts Rehabilitation Commission should be available to alerting stations for consultation with staff, initial vocational screening, and to expedite the movement of clients to appropriate restorative and vocational services as needed.

CONSULTATION TO SCHOOL PERSONNEL

37. Liaison consultation should be provided by specialists from the Massachusetts Rehabilitation Commission to appropriate school personnel to emphasize remediation of disabling conditions at the earliest possible time and to help plan educational programs relating the handicapped child's capacities to the work world.

NOTIFICATION BEFORE SCHOOL TERMINATION

38. Area offices of the Massachusetts Rehabilitation Commission should receive notification before any special class student or other student reported handicapped terminates school.

CHRONICALLY DISABLED PERSONS IN INSTITUTIONS

39. The Massachusetts Rehabilitation Commission and those state departments responsible for operating institutions providing long term care to chronically ill patients should develop collaborative agreements which result in establishing comprehensive rehabilitation services at each appropriate institution. The Massachusetts Rehabilitation Commission should be responsible for reaching out through collaborative arrangements to private and voluntary institutions for the chronically disabled to encourage the development of comprehensive rehabilitation services.

AGED PERSONS IN INSTITUTIONS

40. Specialized consultation services in such fields as psychiatry, physical therapy, occupational therapy, and vocational counseling should be provided to personnel in nursing homes and institutions serving the aged on a demonstration basis to determine the optimal means of preventing institutional deterioration. This special research and demonstration program should be supported by a grant from the Social and Rehabilitation Service of the U.S. Department of Health, Education and Welfare.

WHAT CAUSES VOCATIONAL HANDICAPS?

An individual's vocational handicap may result from a wide variety of causes. A person may be:—

- Suffering from a chronic or progressive physical or emotional illness.
- Retarded and, because of an inborn intellectual defect, unable to compete with his peers.
- A skilled craftsman whose talents have been replaced by automated machinery.
- An illiterate, whose educational deficit keeps him from competing in the labor market.
- Too old to get a steady job.

These causes of handicap are highly varied, ranging from the organic to the emotional and sociocultural. However, they all produce the same end product: an individual unable to hold down a job or to keep house for a family. The roots of vocational handicap are many and occur prior to the development of the problem in job functioning itself.

PREVENTING THE DEVELOPMENT OF VOCATIONAL HANDICAPS

The prevention of vocational handicaps is best accomplished by preventing the handicapping condition from ever occuring. At any particular time we need:

- Information about means of preventing disease and handicaps in general (flouridation, lack of poverty).
- Recognition of our limitations to understand when we do not know enough about a significant disabling condition to suggest the cause, who the most vulnerable populations are, or what the consequent preventive measures should be (schizophrenia).
- Knowledge about avoidable disabling conditions (lung cancer).
- Methods and techniques to avoid the disabling condition (stopping smoking).
- Means to help the population most prone to the handicap to avoid these conditions by changing their behavior (advertisements, laws, education).

Primary preventive measures, those which change the enviroment affecting predispositions of risk populations to disabilities, are not the major responsibility of the professional caregiver. These preventive measures result from legislative, political, and administrative forces in the community acting through laws improving our general social and economic environment, through public and private agency policies and through the general education of the public.

IMPROVING SCREENING TECHNIQUES

Mass screening techniques are essential if potential handicaps are to be uncovered before they become manifest. Various types of screening measures are most effective at different ages, such as glaucoma screening for all adults over 35 and cervical cancer screening in females from adolescence on. Valid screening techniques among our youth are central to preventive care. After the screening which occurs at birth, the next captive audience is children entering public and private elementary schools. Presently, the services provided in school health services are limited in both scope and quality.

Suggestions about the type of examination required to screen for one disability (retardation) in the public schools were presented two years ago in the report of the Massachusetts Mental Retardation Planning Project. Maximum use of technical personnel, rather than highly trained professionals, was recommended to carry out initial screening procedures. While administratively responsible to an experienced professional, technical personnel can be expert in a limited aspect of the screening process such as reflex testing, audiodecibel level or eye chart examination. Initial screening should detect youngsters comprising a risk population.

A high risk group is one in which a strong probability exists that many members of the group will be afflicted with some disability. Persons in such groups should receive a more thorough and comprehensive workup. If appropriate screening techniques exist, this model allows for optimal use of personnel.

However, handicapping conditions can occur at any time in a person's life. Although establishing adequate screening mechanisms during the school years will help, preschool and postschool techniques are also needed. A universal glaucoma screening for people over 35 would detect the disease before its symptoms manifest themselves and may cause individuals to lose their jobs. In varying degrees, the same is true for the detection of cervical cancer, tuberculosis, venereal disease and pernicious anemia.

Effectiveness of any screening technique is a vital consideration. New screening tools are constantly replacing old ones. Changes in the incidence of particular diseases make it necessary to develop tools for screening them. Because of all these factors, a mechanism should be created to:

- Evaluate new information about screening tools and their effectiveness.
- Estimate the number of cases of the disease which the technique can be expected to detect
- Evaluate the degrees to which not picking up this disease will have harmful effects on those suffering from it.
- Develop cost figures for placing a new screening technique into universal application.

To perform these duties, a Health Screening Procedures Review Committee should be established by the Massachusetts Department of Public Health, which has had traditional responsibility in this area. This committee should have the major responsibility for evaluating new screening techniques and for deciding whether they should be implemented on a statewide basis.

In addition to present professional personnel, the committee should include an administrative secretary to provide continuity for the group, two clerical personnel, and various

consultants with a total annual budget of approximately $25,000. Implementation and followup on recommendations of the committee should be the responsibility of the Department of Public Health.

Commission on School Health Examinations

By themselves, specific health screening procedures will not deal with the more general problems of quality control and the standards for insuring competent screening techniques throughout the total health program for school children. Few persons disagree with the premise that the school health system is a primary vehicle for the earliest feasible mass detection of potential vocational handicaps. Yet, most of the present school health programs are inadequate to meet these responsibilities. Therefore, a special commission of representatives from the Massachusetts Department of Public Health, the Massachusetts Medical Society, the Massachusetts School Nurses' League, the Massachusetts Academy of Pediatrics, the Massachusetts School Physicians' Association, and the Massachusetts Principals' Association, should be appointed by the Governor to thoroughly review present policies and to make recommendations for new minimum standards of personnel and procedures to replace the present *Regulations for Physical Examination of School Children in Massachusetts*. Together with the retardation model discussed above, the end product might also include parallel provisions for psychological and psychosocial screening, if and when proven procedures become available.

Inservice Training for School Personnel

Adequate school screening can prevent major vocational handicaps resulting from neglected minor problems such as a lazy eye or mild hearing loss. In addition, children with severe problems of a chronic nature could benefit from the early planning of specific rehabilitative programs designed to make their schooling a more meaningful experience. Planning the vocational future of a disabled child should be an organic part of the educational process.

A major role reemphasis will be necessary for school personnel who provide direct pupil services. They will need to become more familiar with the particular problems facing the handicapped child. To insure that relatively uniform knowledge is disseminated throughout the Commonwealth among these school personnel, the Bureau of Special Education of the Massachusetts Department of Education should provide inservice training concerning problems of the handicapped child to school personnel who provide special pupil services such as guidance counselors, adjustment counselors, nurses, and social workers. Regional conferences should be held periodically by bureau specialists to provide this training. Training and education personnel from the state office of the Massachusetts Rehabilitation Commission should work with the bureau in developing these programs

From a preventive point of view, individual classroom teachers would be able to function more effectively if they had greater understanding about the problems of disability among children, especially as they relate to academic and social performance. Schools of education and state colleges can aid by including a mandatory course on the disabled child within the required education curriculum. In addition, the regional conferences to be held by the Bureau of Special Education might profitably be expanded to include practicing teachers who have not had the opportunity for such course training.

ALERTING STATIONS

Clearly, the school is a primary locus for screening childhood handicaps. In a parallel fashion, all agencies and individuals dealing with the health and welfare needs of the population must be considered potential alerting stations. Not only the school, but the church and physician's office, the hospital and mental health center, the school for the retarded and institutions for correction, the local health department and Visiting Nurse Association, the welfare department and voluntary social service agency can all provide the following alerting station functions:

- Becoming sensitized to the special needs of handicapped persons.
- Discovering persons with potential vocational handicaps.
- Alerting appropriate rehabilitation agencies or personnel about these handicapped persons.

When these types of agencies, which provide direct services to people, are properly sensitized, then they can serve as alerting stations — natural points for finding vocationally handicapped individuals. Professionals can use these alerting stations to find those in need of vocational rehabilitation and alert the appropriate rehabilitation services.

To find and help the greatest number of people, administrative procedures should be developed to allow staff members of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to be sufficiently available to agencies which initially come into contact with the disabled. Listings of all such potential alerting station agencies should be established and kept up to date by the Massachusetts Rehabilitation Commission to insure their coverage. Personnel of the alerting station agencies need to be educated as to the nature of the rehabilitation field so maximum utilization can be achieved. Education of persons employed at agencies serving as alerting stations should be performed through informal day to day contact. To provide daily contact to the alerting stations, these stations should become the major locus of activity for a large number of new Massachusetts Rehabilitation Commission counselors.

LIAISON CONSULTANTS

A new category of personnel, liaison consultants, should be available from the Massachusetts Rehabilitation Commission to work with alerting stations. Liaison consultants should not provide direct services, but should primarily

provide consultation and coordination to alerting stations as follows:

- Consultation to alerting station agency staff concerning vocational rehabilitation.
- Initial vocational screening for eligibility and diagnosis at the alerting station reducing the number of inelegible cases processed at area rehabilitation offices.
- Following initial screening, expediting the movement of eligible clients to appropriate rehabilitation services or to other restorative prevocational services as needed, and of ineligible clients to an appropriate agency or institution.

In addition to the present requirements for rehabilitation counselors, liaison consultants should also have training in the consultation process and in community organization. These background requirements should be reflected in the civil service requirements for the positions.

Liaison consultants should operate under the supervision of either a Liaison Consultation Supervisor or directly under the Area Rehabilitation Director of the Massachusetts Rehabilitation Commission. They should work directly out of these local offices with the caregiving agents within each community in the geographic service area. State office staff supervision and centralized administrative procedures should be initiated by the Director of Liaison Consultation in the Community Programs section of the state office.

Liaison Consultation to School Special Personnel

To provide maximum continuity of service to handicapped school children, a Massachusetts Rehabilitation Commission counselor in each geographic service area should be assigned in a liaison consultant role to the school systems in the area. School professionals have major day to day responsibility for counseling handicapped students and for working with their families. Massachusetts Rehabilitation Commission counselors should alert school pupil service personnel regarding vocational training and job opportunities for particular disability groups and for individuals trained in specific skills. Commission liaison consultants should expedite restorative and other rehabilitative services required by students during school years. Liaison consultants should also coordinate training programs, such as on-the-job training, needed by the student while in school.

Notification Before Termination from School

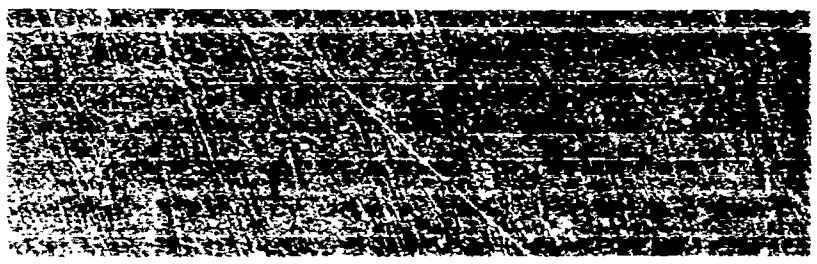
Utilizing the liaison consultant, the Massachusetts Rehabilitation Commission should take ultimate responsibility for every special class student and other students diagnosed as handicapped, who require further rehabilitation services after they leave the school system. This latter function will provide maximum continuity of care, so often lacking today, and should be accomplished through the referral of the student to the local area office of the Massachusetts Rehabilitation Commission. While the present procedure requires school systems to send lists of disabled children leaving school to the Massachusetts Rehabilitation Commission, no guarantee of service is provided. Moreover, because it is a paper referral rather than a counselor to client or counselor to agency communication severe limitations are placed on the probability of continued service unless initiated by the client himself. Thus, many potential clients are lost to the rehabilitation system or start to receive services much later than would be optimal to achieve their maximum rehabilitation.

Implementing the Liaison Consultant Role

A major question resulting from the alerting station innovation concerns the number of rehabilitation counselors required to satisfactorily accomplish an adequate screening and expediting function. Clearly, the number of liaison consultants available to alerting stations should reflect differences in the number of alerting stations in a geographic area, the utilization of these alerting stations, and the desire of the alerting stations to establish relations with the liaison consultant. Some alerting station agencies will require a full time liaison consultant, others a part time liaison consultant, still others a consultant on call.

Assuming the state is divided into the proposed 37 geographic service areas, congruent with the presently defined mental health-retardation areas and based on a population of 75,000 to 200,000 each, the number of additional counselors needed to fulfill this major role of the Massachusetts Rehabilitation Commission should initially be based on population. A minimal base ratio of one liaison consultant per 50,000 people (using the 1960 Census figures) requires 1½ to 4 consultant positions per area and a total statewide need for 111 new consultant positions plus 10 supervisors. In addition, 55 counselors are needed to serve as liaison consultants to the school systems of each area, based on a 1:100,000 population ratio. Assuming a mean salary of $10,500 per counselor and $11,000 per supervisor, the cost of this proposed increase in Massachusetts Rehabilitation Commission functions and staff — once appropriately trained personnel are available — would be $1,819,000 per year. This should be the goal for fiscal year 1976. To initiate the program, it is essential that the Massachusetts Rehabilitation Commission recruit and assign one counselor as a liaison consultant to each geographic service area to begin operations among the alerting stations of the area. This initial beginning would cost the Massachusetts Rehabilitation Commission approximately $390,000 annually.

A consistent referral policy should be initiated and clarified within each alerting station agency to make sure that clients are not lost before possible service. Actual referral procedures should be determined by the specific alerting station agency.



SERVICES FOR CHRONICALLY DISABLED PERSONS IN INSTITUTIONS

Sharp distinctions can be made on the basis of functional impairment among the chronically ill. Certain chronic illnesses such as diabetes, asthma and other disabilities such as amputations, can be controlled by appropriate medication or prosthesis to such an extent that virtually complete rehabilitation will take place. However, another group is made up of people whose disability leaves permanent functional impairment despite efforts to control it. Medicine specifically, and the social services generally, have consistently neglected the training of professionals to meet the needs of this more chronic and unattractive population. Nevertheless, the fact must be faced that chronic malfunctioning is fast becoming the leading health and welfare problem of our nation. As medical technology continues to produce mechanisms for saving lives of individuals even though the person suffers serious disablement, and as the average length of life continues to increase, this trend may be expected to grow rather than decline.

To further insure provision of care to the more severely disabled, comprehensive rehabilitation services should be established in all appropriate state institutions that provide long term care to the chronically disabled. Cooperative agreements between the Massachusetts Rehabilitation Commission and the departments responsible for operating these institutions should be initiated. Private and voluntary institutions for the chronically disabled should also be encouraged to develop comprehensive rehabilitation services by the Massachusetts Rehabilitation Commission through fee for service arrangements and guidance in securing demonstration grants.

SERVICES FOR AGED PERSONS IN INSTITUTIONS

Although the major emphasis of a vocationally oriented program is on the work and prework ages, rehabilitation in the years beyond retirement demands attention as well.

Aging is a relative term. Traditionally the critical age has been 65, the usual time of retirement from work in our society. However, with the combination of automation causing earlier retirements, and with improved health care, environmental manipulation and increasing welfare benefits prolonging the life span, larger numbers of people will be living for longer periods in retirement.

The vocation of the aged in our society is ill defined. From the point of view of functional capacities, there should be as great a responsibility to make maximum use of the remaining capacities of older citizens as of any other functionally disabled group. Presently, rehabilitation services being offered our senior citizens, particularly within institutions for the elderly, are severely limited. As a result, serious physical and psychosocial deterioration takes place among the population at a rate which could be reduced through appropriate rehabilitation programs. Prevention of further functional deterioration can be implemented, even among the aged.

Recent studies by the Easter Seal Society, by the Massachusetts General Hospital and by the Massachusetts Department of Public Health all point to a major gap in the provision of rehabilitation services at the custodial care stage, particularly within nursing homes in the Commonwealth. Both physical rehabilitation (physical therapy, fitting and use of prosthetics and orthotics, occupational therapy and rehabilitation nursing) and the psychosocial therapies such as social service, psychiatric consultation and recreational/vocational services are deficient. Reasons for these inadequacies are numerous and complicated, and include a general social attitude of denial of the aged, the cost of developing adequate facilities, and the pervasive lack of optimism by professionals towards working with a population which will inevitably go downhill. Consequently, the burden of responsibility has fallen to the nursing home personnel who tend to become isolated from outside professionals. This isolation limits the scope of the nursing home personnel, as they are unable to profit from cross fertilization of ideas in an open professional climate, such as that existing in major teaching hospitals.

To help remedy this situation, specialized consultation services in such fields as psychiatry, physical therapy, occupational therapy and vocational counseling should be provided to personnel in nursing homes and institutions serving the aged on a demonstration basis to determine the optimal means of preventing institutional deterioration. This special research and demonstration program should be supported by the Social and Rehabilitation Service of the U.S. Department of Health, Education and Welfare.

Even with such measures, there is a strong probability that these services will not develop voluntarily on a large scale, throughout what is a largely proprietary business. The high cost of developing additional rehabilitation services for the patients and the shortage of competent nursing homes will minimize such efforts. Regulatory measures may be necessary to raise the quality of care in nursing homes throughout the Commonwealth under the supervisory responsibility of the Massachusetts Department of Public Health.

PRIORITIES

A large unserved population of handicapped persons exists throughout the Commonwealth and many new services need to be developed, particularly in the areas of consultation and in the organization of community resources. A major consequence of this disparity between needs and resources is that decisions will have to be made regarding priorities for funding new programs and personnel.

Regardless of whatever individual priorities are developed locally, the recommendations for alerting station agencies, placement of liaison consultants at these agencies, and development of broadened relations with the professional community represents the cornerstone for proposed program development.

VOCATIONAL EVALUATIONS

RECOMMENDATIONS

EXPEDITING CLIENT EVALUATIONS

41. The Rehabilitation Facilities Board should designate one or more agencies in each geographic service area as disability evaluation centers and the Massachusetts Rehabilitation Commission should contract with the designated centers to conduct vocational evaluations for all disabled and disadvantaged persons requesting vocational rehabilitation services. Centers should be designated from among agencies such as general hospitals, sheltered workshops, or rehabilitation centers.

EVALUATIONS BY INTERDISCIPLINARY TEAMS

42. Preliminary disability assessments and vocational evaluations should be conducted by an interdisciplinary team composed of at least a physician, rehabilitation counselor and social worker, and in the case of mental disability, an expert in emotional disorders or mental retardation.

COMPREHENSIVE VOCATIONAL EVALUATIONS

43. Clients who are found to require a comprehensive assessment of their disability should receive services from an interdisciplinary team including all professionals who may be required to arrive at an adequate assessment and vocational plan.

REVIEW OF CLIENTS NOT SERVED

44. If as a result of the comprehensive evaluation, it is decided that no suitable services are presently available for a client, his case should be submitted for review to a designated staff committee of the disability evaluation center or the mental health-retardation center.

ROLE OF REHABILITATION COUNSELORS IN AREA EVALUATION SERVICES

45. Staff members from the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should participate on the interdisciplinary teams of every area disability evaluation center and mental health-retardation center to help assess client disability and expedite referral to appropriate services.

DISABILITY REHABILITATION CENTERS

46. The Rehabilitation Facilities Board should designate at least one general hospital or rehabilitation facility in each area as a disability rehabilitation center. The Massachusetts Rehabilitation Commission should contract with the designated rehabilitation centers to provide restorative services which are not otherwise available in the area.

These services should be provided to clients who no longer require intensive medical care, but need speech therapy, physical therapy, postoperative selfcare training and other transitional services to prepare them for competitive or sheltered employment.

VOCATIONAL SERVICES AT MENTAL HEALTH-RETARDATION CENTERS

47. Mental health-retardation centers should place a greater emphasis on the vocational adjustment of their clients by expanding services such as vocational evaluations, vocational counseling, vocational training, placement and followup.

EXPEDITING CLIENT EVALUATIONS

Physically disabled, mentally disabled and socially disadvantaged persons should be able to receive an adequate vocational assessment leading to appropriate treatment, training or education to prepare them or return them to optimum functioning. Such services do not require a multifaceted program in one building. The task can be accomplished by a network of agencies in each area working cooperatively under the overall guidance of an expediting agency which establishes necessary contacts, follows up referrals and guides the client through the usually complicated process.

One of the serious bottlenecks to helping people through the rehabilitation process is the manner in which evaluations are made by state rehabilitation agencies. Sometimes a client has to wait for months before eligibility for the public rehabilitation program is determined and a rehabilitation plan developed. One reason for this delay is the fragmented

method of collecting a variety of medical, psychological, and vocational examinations and evaluations upon which to base a complete assessment of a client's potential for rehabilitation. This bottleneck in the evaluation of a client's potential should be eliminated by instituting comprehensive team evaluations which could be completed in short periods of time.

Emphasis should be placed on making sufficient resources available in each geographic service area to conduct necessary evaluations. Existing facilities should be utilized whenever possible. The Rehabilitation Facilities Board of the Massachusetts Rehabilitation Commission should designate one or more agencies in each geographic service area as disability evaluation centers and work adjustment centers for the purpose of conducting vocational evaluations. The Department of Mental Health should provide vocational evaluations for mentally disabled persons at their community mental health-retardation centers. Vocational evaluations would then be available in each area as follows:

- For those with primarily physical disabilities, area disability evaluation centers such as hospitals should be designated.
- For those with primarily mental disabilities, area mental health-retardation centers or other evaluation resources utilized by area mental health-retardation centers programs under the Mental Health Reorganization Act of 1966 should be designated.
- For those with primarily undifferentiated vocational or social disabilities, designated area workshops or other work adjustment or evaluation centers to be activated under the provisions of Section 15 of the Vocational Rehabilitation Act as amended in 1968, should be used.

The Massachusetts Rehabilitation Commission should contract with designated centers to conduct vocational evaluations for all physically disabled and socially disadvantaged persons requesting vocational rehabilitation services. From National Health Survey extrapolations and other data, it may be conservatively estimated that about 5,500 persons out of every 100,000 in the population (5½%) would require vocational evaluations, for reasons of physical or mental disability alone. This survey also indicates that this number will increase by more than 900 every year. No estimate is available for the number with undifferentiated vocational or social disabilities.

It is estimated by the Planning Commission that one team of professionals (see below) can evaluate about 500 persons annually. In view of the potentially large numbers of persons requiring vocational evaluations, the Massachusetts Rehabilitation Commission should designate a number of general hospitals, rehabilitation centers and workshops in each area as disability evaluation centers. Mental health-retardation centers, should expand their vocational evaluation services.

COMPONENTS OF VOCATIONAL EVALUATIONS

A vocational evaluation assists staff to make a judgment regarding the client's potential for vocational functioning. In addition, services required to reach that potential are determined based on an assessment of the client's limitations as well as the positive aspects of his functioning and on his overall situation.

Information should be evaluated with respect to the client's physical condition, his personality, his work skills, social skills, and other significant aspects such as family relations and educational history.

Agreement on what comprises an adequate vocational evaluation is often difficult to obtain. Innumerable differences exist related to the extent and type of disability and the orientation of various preferences. The following list is suggested as basic for determining the work potential of a client:

- Willingness to work
- Amount of work accomplished
- Learning and remembering work
- Ability to work when work piles up
- Amount of supervision needed
- Quality of work
- Relationship with other workers
- Personal behavior on the job
- Ability to make use of suggestions and directions
- Ability to work alone

EVALUATIONS BY INTERDISCIPLINARY TEAMS

Some disabled persons may only need help in finding a job; some may need further evaluation and training; some may never be able to work. Therefore, a major emphasis must be placed on providing adequate vocational evaluations. On the basis of a person's total functioning, determinations should be made of whether or not additional services are needed and the nature of these services.

All clients of the disability evaluation centers should receive at least a preliminary vocational evaluation conducted by an interdisciplinary team composed of at least a physician, rehabilitation counselor and social worker. In the case of mental disability, the team should include an expert in emotional disorders or mental retardation. Full use should be made of relevant information collected by other agencies through a confidential information exchange service among agencies. Repetitious gathering of information is not only a waste of professional time but an undesirable burden upon the client. The preliminary evaluation should be the basis upon which additional services are provided.

A major task for a vocational evaluation is to integrate the judgment of a number of different professionals and to take action on the client's behalf resulting in optimum work adjustment. Every vocational evaluation should contain a vocational plan and specific recommendations for the next steps. With each profession best equipped to evaluate the client from the viewpoint of their specialty, team evaluations are necessary to assess the client's vocational strengths and liabilities holistically and to mutually arrive at the soundest vocational plan.

EARLY VOCATIONAL EVALUATIONS

A great length of time frequently elapses between the onset of disability and the start of rehabilitation. Reducing this time gap is crucial in minimizing the negative results of disability. Vocational evaluations should take place early and vocational services should soon follow. Mental patients are now encouraged to work in the hospital as soon as possible after admission. Similarly, rehabilitation programs for the sick or injured can enhance a patient's full recovery by early consideration of vocational counseling and work activity, as an adjunct to the patient's treatment.

UTILIZING THE CLIENT'S OWN VIEWPOINT

Too little significance is generally attached to the client's own view of his problem and of his proposals. Participation of the client in the rehabilitation process may not only provide valuable clinical insights but enhance his motivation to work along in his recovery process. Client decision making should also be expanded to include the client's choice of workshop and other vocational services where possible, just as Medicare and Medicaid provide patients the freedom of choosing physicians and hospitals.

COMPREHENSIVE VOCATIONAL EVALUATIONS

If the preliminary vocational evaluation does not yield enough information to result in a plan of procedure, the team should draw upon additional professionals, as consultants. Psychologists, opthamologists, neurologists and orthopedists are illustrative of the types of professionals who might be needed to help assess certain multiple problems.

REVIEW OF CLIENTS NOT SERVED

Basically, the philosophy of the disability evaluation center and the mental health-retardation center should be to provide services to as many clients as possible by serving them directly or referring them to appropriate community agencies. Even under the best circumstances these centers will not be able to provide adequate services for many older adults or for multiple and severely handicapped persons, until community resources and methods for serving these clients improve. Some clients may be too seriously disabled to profit from existing services. However, the ultimate decision that a client cannot be served is too serious to be left only to the evaluating team. If appropriate services do not seem to be available, the case should be submitted to a review committee on the disability evaluation or the mental health-retardation center for review, consultation and further disposition.

Clients for whom services are not presently available or feasible should have their cases remain active. These cases should be periodically reviewed in the hope that favorable action may be possible in the future.

ROLE OF REHABILITATION COUNSELORS IN AREA EVALUATION SERVICES

At the present time, counselors of the Massachusetts Rehabilitation Commission send clients who may be eligible for the vocational rehabilitation program to various professionals for medical, psychological and other appropriate evaluations. When these reports have been completed, the counselor develops a vocational plan and initiates the process of treatment and/or training. The major problems with this procedure is the length of time from initial referral to the beginning of a program of services, the fragmented nature of the evaluation and the absence of a team to help formulate the vocational plan.

Staff members from the Massachusetts Rehabilitation Commission should play the dual role of professionals and expediters. They should be members of the evaluation centers, mental health-retardation centers and the work evaluation centers to make their professional contribution to the team evaluation.

These counselors should then assume overall responsibility for a client and expedite his progress through the entire rehabilitation process.

Staff members from the Massachusetts Commission for the Blind might assume this responsibility for blind clients and staff members from the mental health-retardation center for mentally disabled clients. Following vocational evaluations, socially disadvantaged persons should be referred back to the agency which initiated their evaluation.

If possible, the counselor's office should be in the same building adjoining the evaluation centers to minimize travel expenses and travel time and to facilitate team evaluations. This means that if the mental health center and the disability evaluation center or the area workshop are near each other, counselors working with both centers can utilize joint office space. If the centers are separated, the Massachusetts Rehabilitation Commission should have office space at each location. This recommendation does not mean that the Massachusetts Rehabilitation Commission should construct new buildings but rather should accomodate themselves within existing structures. However, if new mental health centers, workshops, or disability evaluation centers are constructed, provision for Massachusetts Rehabilitation Commission personnel should be made.

Counselors working at evaluation centers should have sufficient administrative and clerical personnel to perform intake, clerical and record keeping functions.

Referrals from alerting stations would come directly to the appropriate evaluation center and would receive further processing by the counselor(s) working there. Those clients for whom little can be done, on the basis of a comprehensive evaluation, should be reevaluated at least every three years. As new methods and techniques for rehabilitating more severely disabled clients are developed, counselors should review cases which they were previously unable to serve.

DISABILITY REHABILITATION CENTERS

Area disability rehabilitation centers should provide restorative services such as physical therapy, occupational therapy, speech therapy, post operative self care training and social services. Services should be available for inpatients and outpatients. A patient with a stroke, who has made an initial recovery in the local hospital, may be aphasic and require speech and hearing therapy services not available at the hospital. He would need admission as an inpatient at the rehabilitation center. There he would receive speech therapy while continuing his recovery. Once he has sufficiently recovered not to require nursing care, he could return home and continue his speech therapy as an outpatient.

A local hospital may discharge a person who has sufficiently recovered from a fractured leg. However, because of certain complications, he requires ongoing physical therapy. Since he is mobile, he should receive this physical therapy as an outpatient of the local hospital. If this service is not available at the local hospital he should become an outpatient of the disability rehabilitation center.

A patient discharged from a hospital in a large city of the Commonwealth following recovery from a mastectomy or a colostomy still requires help. He should return to his area disability rehabilitation center as an inpatient to learn to care for his stoma. Such patients no longer require intensive medical care. They require training in speech, mobility, self care or with other functions to help smooth the transition between the acute phase of their illness and their return home. During this period some patients may require different levels of nursing care, others may require none. The clinical services of the disability rehabilitation center should be professionally affiliated with one of the general hospitals or with a veteran's administration hospital in the area. To reduce the per bed cost and to provide courtesy privileges to all referring physicians, the unit should not be an integral part of the hospital but should have its own administrative entity as a disability rehabilitation center. This is feasible since the clients being served no longer require hospitalization or intensive medical care.

SIZE AND COST OF REHABILITATION CENTERS

The Berkshire Rehabilitation Center in Pittsfield, the Massachusetts General Hospital Rehabilitation Unit, and a rehabilitation center being planned by the J.B. Thomas Hospital in Peabody vary in size from 12 to 30 inpatient beds, in the type of patients they serve and in the range of services they provide. The existing rehabilitation centers in Massachusetts indicated that they needed more inpatient beds. A survey conducted by the J.B. Thomas Hospital in Peabody (which is planning to construct a rehabilitation facility) of the Essex County South Medical Society for an area of about 400,000 persons, showed that a 25 bed inpatient facility was needed for that area. Federal standards urge a rehabilitation facility for every 75,000 persons in the population.

Where construction of a rehabilitation facility is contemplated, similar surveys should be undertaken by each area to determine the size of the facility needed as accurately as possible. If physical therapy, occupational therapy, speech therapy, social services and other services are purchased on an inpatient and outpatient basis from local hospitals, the extent of the services required in each area can be determined by specific requests for services over a period of time.

The possibility should be considered that rehabilitation centers with less than 35 inpatient beds may be uneconomical to run. Two areas may wish to jointly contract for services from one rehabilitation center where size and economy are a factor.

Estimates for per bed costs for a rehabilitation center range from $15,000 to $30,000 annually. This wide discrepancy is mainly attributable to the intensity of medical care required by patients. Where rehabilitation centers accept patients no longer requiring intensive medical care per bed costs would be reduced t. ards the lower estimated amount. Where the rehabilitation center shares nursing staff, food service, laundry and maintenance, costs can be further reduced.

Third party payments for patients by insurance companies, the Massachusetts Rehabilitation Commission and other public and private agencies may offset up to 85% of the gross cost.

THE TEAM APPROACH

When possible, the same team of professionals who conduct client evaluations should provide inpatient and outpatient care. More than one team may be needed in each center, depending on the demand for services.

A team approach is necessary to provide coordinated restorative and vocational services to the individual and to avoid damaging fragmentation of services. There is considerable emotional cost to a client who is shuttled from one service to the other with each profession seeing the patient from a different point of view.

A rehabilitation team is almost invariably required to work with the individual person to strengthen his physical, mental and social capacities in order for him to deal adequately with a work situation. Composition of the team is affected by the nature of a person's disability, his age, the chronicity of his problem and his own perception of his disability. Roles of various team members also change as treatment progresses. The role of the physical therapist and rehabilitation counselor would assume increasing importance at the conclusion of the acute phase of a patient's illness as the role of the physician diminishes.

Generally, physical and mental restorative services precede vocational evaluation and training. However, this should not suggest that restorative services should be completed before vocational services begin. Rehabilitation counselors should function from the outset as a team with those professionals providing physical and mental restorative services so that they can work with the client to prepare him for evaluation, training and other appropriate services, and ulti-

mately for work. Counselors should be in a position to make an ongoing assessment of the client's work potential and to assume an increasingly significant role with the client as the emphasis changes from restorative to vocational services.

VOCATIONAL SERVICES AT MENTAL HEALTH-RETARDATION CENTERS

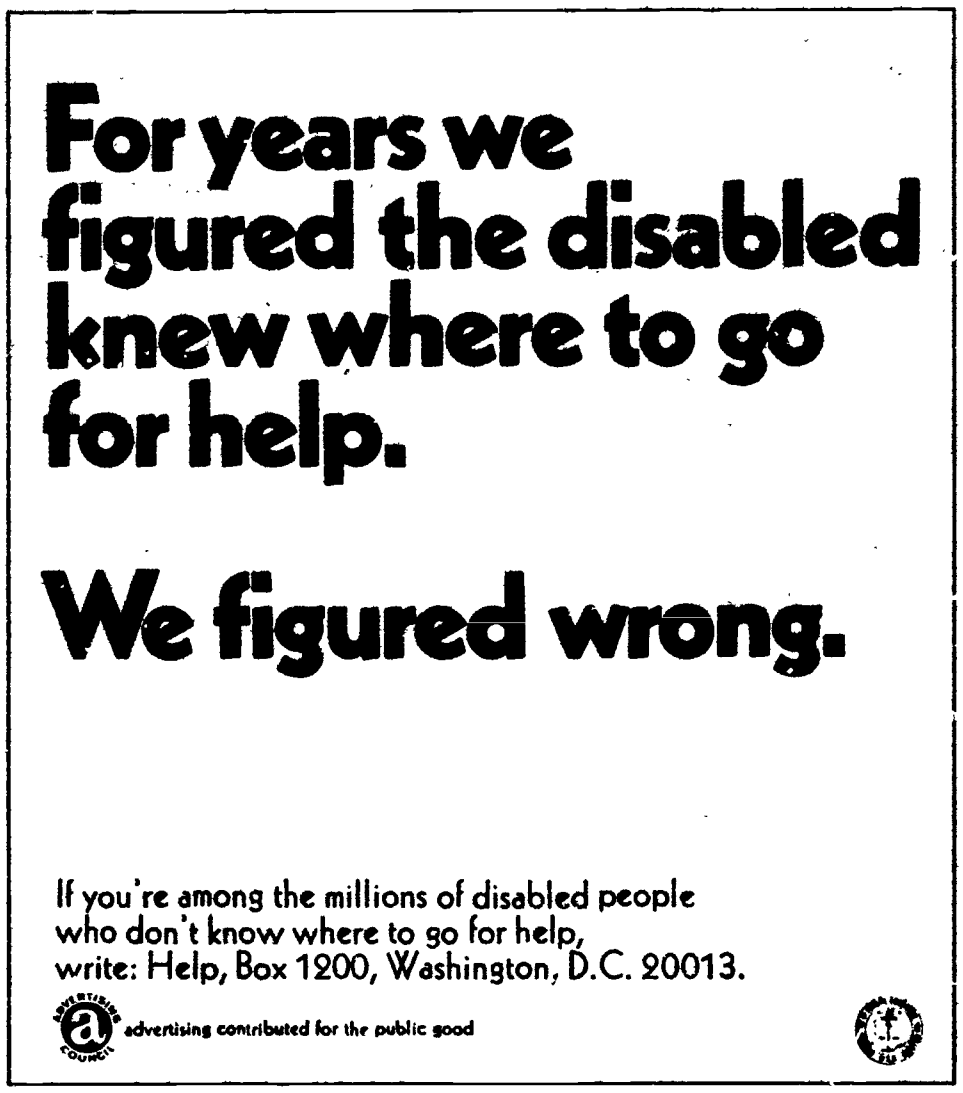
Community mental health-retardation centers are the major resource in each area for vocational evaluations, training and placement and followup services for mentally disabled and retarded persons. These responsibilities closely resemble those carried out by the disability evaluation centers on behalf of the physically disabled and chronically ill. In addition, the mental health-retardation centers also provide a central registry and funds certain client services.

With the national trend emphasizing the use of work training programs and consistent reports in the research literature describing the success of work therapy programs with a variety of disabled populations, the mental health-retardation center should expand vocational rehabilitation services such as evaluation, training and placement for both inpatients and outpatients.

Staff members of the mental health-retardation center responsible for vocational evaluation should have an understanding of the work of work and the interacting factors between disabilities and their implications with regard to work. They should be able to evaluate skills, training ability, attitudes, motivations, work habits, personality strengths and weaknesses of mentally disabled persons in a work setting. Following the evaluation, jobs must be analyzed into their various components and a meaningful plan constructed.

Training resources can be provided within the framework of the mental health-retardation center or in cooperation with other community, public and private resources. The center has the responsibility to provide vocational training opportunities directly as a part of the regular treatment program or indirectly through contractual arrangements. This also includes job related, personal adjustment training to assist the individual to acquire personal habits, attitudes and skills that will enable him to function effectively.

Wherever possible, programs should be directed toward the eventual end of competitive employment. But, the mental health-retardation center should also organize, coordinate and expand alternative forms of placement such as extended sheltered employment or homebound employment for those persons not going into competitive employment.



REHABILITATION OF THE HANDICAPPED CAMPAIGN
MAGAZINE AD NO REH-9-69--4-9/16" x 5"

TRAINING, SHELTERED EMPLOYMENT AND EDUCATION

RECOMMENDATIONS

COMPONENTS OF VOCATIONAL EDUCATION AND TRAINING

48. A broad range of educational and training programs should be available to disabled and disadvantaged persons throughout the Commonwealth, as close to where they live as feasible, and should include at least the following:

- Personal adjustment training (prevocational)
- Training in work habits
- Training in specific job skills
- On-the-job training
- Vocational-technical education
- Undergraduate and professional education

Area Sheltered Workshops

AT LEAST ONE WORKSHOP PER AREA

49. At least one sheltered workshop should be designated in each geographic service area by the Rehabilitation Facilities Board as a major resource for persons requiring prevocational training, vocational training, extended sheltered employment, homebound employment and day activity programs.

Area workshops should be designated from among existing workshop resources whenever possible.

COMPREHENSIVE WORKSHOP SERVICES

50. A comprehensive array of services should be available to sheltered workshop clients, either directly or by arrangement with other agencies, including the following:

- Comprehensive evaluation (vocational, psychological, social).
- Personal adjustment training.
- Prevocational and specific job training.
- Suitable vocational placement, competitive and sheltered.
- Followup services.
- Social and recreational programs (during and after working hours).
- Individual and/or group counseling.
- Supportive medical services.
- Remedial education.
- Habilitation training (use of public transportation, banking, budgeting).
- Classes in health, grooming and etiquette.
- Improving communication skills.
- Transportation.

A MIXED CLIENTELE

51. Area sheltered workshops should serve a mixed clientele such as physically handicapped, mentally retarded, emotionally disturbed, chronically unemployed, the aged and other handicapped persons who can benefit from workshop services.

FUNDING OF WORKSHOPS

52. Area sheltered workshops should be multiply funded by those agencies purchasing services from them for their clients.

Although the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind may provide the majority of workshop clients the Departments of Mental Health, Public Health, Public Welfare and Corrections, should actively utilize workshop services to aid the vocational rehabilitation of their clients who are living in the community.

CERTIFICATION OF WORKSHOPS

53. Area sheltered workshops should be certified by the proposed Rehabilitation Facilities Board.

POOLING SUB CONTRACTS

54. The Massachusetts Chapter of the National Association of Sheltered Workshops and Homebound Programs and the Rehabilitation Facilities Section of the Massachusetts Rehabilitation Commission should collaborate to pool sub contract work procured from federal, state and other sources and distribute it equitably to area sheltered workshops.

WORK CONTRACTS FROM THE COMMONWEALTH

55. Appropriate work such as printing of stationery, production of highway equipment and bookbinding should be contracted to area sheltered workshops by the Commonwealth.

Services to be performed by workshop clients outside of the workshop such as landscaping, building maintenance, clerical work and carpentry should also be contracted by the Commonwealth.

PAYING THE MINIMUM WAGE

56. Every effort should be made to pay clients in sheltered workshops the federal minimum wage.

A study commission should be appointed by the Commissioner of the Massachusetts Rehabilitation Commission to investigate how federal and state wage supplements can be used for clients who cannot earn the minimum wage.

SHELTERED WORKSHOPS IN RESIDENTIAL FACILITIES

57. Appropriate inpatient facilities operated by the Departments of Public Health, Mental Health, and Corrections should establish sheltered workshops emphasizing vocational evaluation training services, and where feasible, assistance in vocational placement.

COORDINATORS IN SHELTERED WORKSHOP PROGRAMS

58. Full time positions for Coordinator of Work Training and Sheltered Workshop Programs should be established by the Departments of Public Health, Mental Health, Corrections and Education to provide consultation to their personnel in workshop programming and funding, to help develop and set sheltered workshop standards for their respective departments and to provide interdepartmental liaison.

ADDITIONAL STAFF RESOURCES

59. The Rehabilitation Facilities Section of the Massachusetts Rehabilitation Commission should provide consultation to workshops on the development of programs and supportive services, information on new methods and techniques and technical assistance on financial and administrative problems.

To fulfill these responsibilities at least six professionals with specialties in areas such as workshop programming, evaluation and accounting should be added to the staff of the Rehabilitation and Facilities section.

EXTENDED SHELTERED EMPLOYMENT

60. Extended employment workshops should be available in every geographic service area to provide sheltered employment to mentally and physically handicapped persons, who are unable to meet the present demands of competitive employment.

STIMULATING THE USE OF FEDERAL GRANTS

61. The Rehabilitation Facilities Sections of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should stimulate and assist the staff of area sheltered workshops to apply for federal grants for construction, staffing facility improvement and technical assistance, available under the federal Vocational Rehabilitation Act.

USE OF LAIRD GRANTS

62. The Massachusetts Rehabilitation Commission should seek an opinion from the Attorney General of the Commonwealth as to the constitutionality of using funds donated by private rehabilitation facilities to match federal vocational rehabilitation monies (Laird Grants).

If constitutional, the Rehabilitation Facilities Sections of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should encourage and assist rehabilitation facilities in utilizing all Laird monies alloted to the state.

HOMEBOUND EMPLOYMENT

63. Homebound employment should be developed in each area by the area rehabilitation director for persons who are capable of work but whose disability restricts them to their homes.

Chapter 149, Section 146F, of the Massachusetts General Laws should be changed to permit workshops to act as intermediaries between employers and homebound workers.

GRADUATE TRAINING ON WORKSHOPS

64. Colleges and universities in the Commonwealth conducting graduate programs in rehabilitation should include courses in workshop administration, workshop programming, and workshop evaluation similar to those offered by Northeastern University.

QUALIFICATIONS OF WORKSHOP DIRECTORS

65. Regulations of the Rehabilitation Facilities Board should require directors of area sheltered workshops to have professional training in workshop administration and rehabilitation programming.

WORKSHOP BOARDS

66. To increase citizen participation and support and to provide additional expertise, sheltered workshop boards should include members with a background in business, education and administration.

Vocational, Technical, Undergraduate and Professional Education

EDUCATIONAL OPPORTUNITIES

67. The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should increase opportunities for their clients to receive vocational, technical, undergraduate and professional education.

68. Utilization of vocational high schools to educate disabled youths and adults should be increased. Where it is not practical to use the facilities during normal school periods, special afternoon, evening, Saturday, and summer schedules should be arranged by area rehabilitation directors and local school committees.

GOVERNOR'S COMMISSION ON HIGHER EDUCATION FOR THE DISABLED

69. A temporary Governor's Commission should be appointed to recommend methods of increasing educational opportunities for qualified disabled persons in technical, undergraduate and professional schools.

COMPONENTS OF VOCATIONAL EDUCATION AND TRAINING

Vocational education and training should provide a broad range of learning opportunities including specific job training at various levels of accomplishment as well as generic work training fundamental to any successful placement. For many persons, generic job skills such as punctuality, grooming, care of equipment and the ability to get along with others are more difficult to master than specific job skills. Therefore, generic skills should receive a major emphasis in all vocational training programs.

A full range of specific job skills related to available employment should also be available in each area to prepare persons for competitive employment in industry, service occupations, and self employment. Training should also prepare persons with reduced working capacities for homebound employment, on-the-job training, transitional employment, work study programs and extended sheltered workshops. Training programs in each area should vary to accomodate the requirements of a variety of clients and should include at least the following:

- Personal adjustment training (prevocational)
- Training in work habits
- Training in specific job skills
- On-the-job training
- Vocational school training
- Undergraduate and professional education

AT LEAST ONE WORKSHOP PER AREA

Sheltered workshops comprise an important resource for vocational evaluation and training. Generic and specific work skills of clients can be evaluated over a period of time in a simulated job setting. Work demands can be adjusted to client levels. Workshop staff play the role of work supervisors as well as teachers and contribute to the evaluation of

the clients' progress and readiness for placement. Individual and group counseling, recreation and academic skills should be made available to workshop clients in support of training goals.

Workshops can also play an important role as a community placement for residents from mental hospitals, schools for the retarded, prisons and other institutions. Used in conjunction with halfway houses and other supportive services, workshops can provide residents with an important link between the institutions and the community.

Many multiply handicapped individuals as well as aging adults and persons with limited sight and hearing are difficult to place in competitive employment even when they have the necessary skills. There are also large numbers of persons who cannot work competitively because of their personality and lack of motivation. However, such persons may be capable of limited productivity and need extended sheltered employment.

Extrapolations of the National Health Survey indicate that in every geographic service area of the Commonwealth between 2,500 and 10,000 persons under 65 years of age are not gainfully employed due to a physical or mental disability, not including mental retardation, or are severely handicapped by their condition. Many of these clients need sheltered workshop services. Eighty-two per cent of the sheltered workshops in Massachusetts are located outside of major cities. Workshops are needed in all parts of Massachusetts. Workshop services should be available to clients with varied disabilities and to those who function on a level requiring extended workshop services.

At least one workshop should be available in each area to provide transitional and extended employment services to a mixed clientele of about 150 - 200 persons, composed of mentally retarded, physically disabled, and mentally ill persons. There are a number of advantages to this arrangement.

- Larger groups of disabled people can be served.
- Program content will be enriched since disabled individuals have varying abilities permitting a wide range of work to be undertaken.
- Costs to operate the workshop can be shared by a number of agencies.
- Opportunities to recruit qualified staff will increase because the workshop responsibilities will be broader and offer greater challenge.
- Transportation of clients will be easier.
- The setting is less depressing for more severely disabled clients.

Additional workshop services should be made available in each area, where feasible in collaboration with industry, to train socially disadvantaged persons to fill available positions in the labor market.

Workshop services are needed in every area to meet the requirements of a mixed clientele having three levels of disability:

- Transitional workshop services should offer up to 18 months of evaluation plus additional training with expectation that clients can then undertake competitive employment.
- Extended workshop services should be rendered to persons who may never be capable of competitive employment but who can fulfill less demanding work responsibilities.
- Day activity programs should be offered for persons for whom the concept of work is not meaningful or who are too severely disabled to do any form of work. Such a program would stress self care skills, recreation, and social interaction.

What is envisioned for each area is an expanded concept of a sheltered workshop, almost a multiservice center. At least one such workshop should be certified by the Rehabilitation Facilities Board in each of the 37 geographic service areas.

PRESENT WORKSHOP SERVICES IN MASSACHUSETTS

At the present time, a number of different systems serve the vocational rehabilitation needs of disabled individuals throughout the Commonwealth. Sheltered workshops are an important aspect of rehabilitation services. Their use varies considerably. The Department of Mental Health developed workshops in many of their residential facilities while other departments make little or no use of workshops for their clients. One of the major problems results from the lack of set criteria for classifying, certifying and defining workshops. What may be termed a workshop by one public agency may be classified as a prevocational training center by another agency.

Workshop data collected by the Massachusetts Rehabilitation Commission and the Vocational Rehabilitation Planning Commission for a 12 month period — 1966-1967 indicates that the more than 40 workshops in Massachusetts vary greatly in size, in the services offered and in the types of clients they serve.

A total of 5,761 persons received workshop services in Massachusetts. Of these, 2,115 clients, almost 38% of the total, were served by Morgan Memorial Goodwill Industries. Almost 23% of the total, 1,350 persons, were served by the Salvation Army which does not consider their services workshops, but rather rehabilitation centers. Between them, these two voluntary organizations account for 61% of all workshop services in Massachusetts.

By contrast, 12 workshops serving the mentally retarded exclusively, accounted for 314 clients, or about 6% of the total.

Daily capacity of all workshops was approximately 1,868 clients.

The average number of persons served daily was 1,590 or 85% of workshop capacity. Two hundred and twenty persons were awaiting service at the time of the survey. Some were awaiting services in agencies not filled to capacity pending completion of their evaluations or the particular service they required was filled to capacity.

Workshop client load ranges in size from five clients per year to 1,750 clients per year. Larger workshops serve a

variety of disability groups but the majority of workshops serve a single disability group.

Currently, 16 areas of the state do not have a single workshop facility.

UNDERUTILIZATION OF WORKSHOPS

At the present time, the sheltered workshops in Massachusetts are not being fully utilized and function below capacity. A variety of reasons have been suggested for this by directors of programs, university instructors and professional workers.

- There is a general lack of knowledge and information concerning sheltered workshops by the general and professional public.
- The majority of workshops currently operating serve a single disability population.
- Many workshops provide a limited array of services to their clients.
- Workshops are often not located in parts of the state where they are needed.
- Poor referral procedures and coordination.
- Some workshop fees are so high that individuals cannot afford them unless they are sponsored by a public vocational rehabilitation agency or voluntary group.
- The image of many sheltered workshops is generally poor.

Present underutiiization of some workshops leaves the false impression that such services are not urgently needed. By bringing workshop progran. into the mainstream of vocational rehabilitation services resulting in improved casefinding, serving multiply handicapped clients and by expanding extended employment services, the need for workshops will soon be seen in perspective, as an intensive component of other local rehabilitation services.

Workshop clients should include persons with disabilities not typical to the present workshop setting such as the public offender, disadvantaged, narcotic addict, alcoholic, school dropout, and the aged. Improved casefinding procedures will have to be developed so that clients with these kinds of disabilities are referred for workshop services.

In other states, sheltered workshops have assumed the major responsibility for providing selected services to all of the clients of the state rehabilitation agency such as comprehensive evaluation, apprentice trade training and postplacement followup. A number of workshops have provided extensive and varied extended employment programs.

Expansion of extended employment programs in workshops in the Commonwealth requires specific attention. Both public and private rehabilitation agencies are reaching out to provide their services to the severely and multiply disabled client. Many of these people, following comprehensive evaluation and training, may not be able to enter the competitive labor market and will require meaningful, but sheltered work settings, for many years. Other clients may need sheltered employment for their entire life.

Improved casefinding and the provision of services to clients, until now not served, will eliminate the underutilization of some present workshops and will necessitate the establishment of workshop programs in every service area of the Commonwealth.

DEFINITION AND PHILOSOPHY OF SHELTERED WORKSHOPS

A sheltered workshop is a work oriented rehabilitation facility with a controlled working environment and individualized vocational goals. Work experience and comprehensive related services are utilized to assist handicapped people to progress toward normal living and a productive vocational status. Sheltered workshops can serve as both transitional and extended employment situations.

Many rehabilitation facilities in hospitals and other institutions provide vocational services such as evaluation, counseling, and training, similar to those provided in workshops. However, the unique contribution of the sheltered workshop is that they pay their clients for the work they perform and services are available to persons living in the community.

In the sheltered workshop environment, handicapped workers have the opportunity to work at a pace suitable to their individual capabilities. Supervisors assist clients to make the best adjustment to the working environment rather than to just meet production schedules. This rehabilitation approach, including supportive social, medical and psychological services, provides an effective environment enabling an individual to move from dependent status to a productive and more independent life.

Some workshops emphasize supportive services such as counseling, social-recreational experience, group discussions and work closely with families and with prospective employers. Other workshops extend their function beyond these services and also use the setting for demonstrating new methods and techniques for the preparation of handicapped persons for employment.

In contrast, some workshops only provide work experiences patterned as closely as possible to actual working conditions and prepare the clients for competitive employment. The majority of workshops fall somewhere between these extremes.

STAGES IN THE WORKSHOP PROCESS

Clients should have access to supportive services, either in the workshop itself or elsewhere in the community to attain the fullest possible rehabilitation. The following six stages should be part of a modern workshop:

- Intake process
- Work evaluation, or tryout period
- Personal adjustment prevocational training
- Work conditioning and job training
- Job placement, competitive and extended
- Followup

Intake Process

Intake should be the responsibility of a trained interviewer such as a vocational counselor or a social case worker. A thorough knowledge of the agency's philosophy, objectives and functions, a warm and understanding approach to the handicapped applicant and the capacity to make realistic evaluations are required. Evaluations should include the following:

Medical Evaluation

Complete medical information should be obtained and all possibilities for remedial treatment considered. Workshop plans for an individual should not be developed until this information is available.

Psychological Evaluation

Development of a sound rehabilitation plan also requires evaluation of the applicant's intelligence, learning ability, occupational attitudes and preferences, and his social maturity.

Social Evaluation

Evaluation of the applicant's social history is essential at intake to plan intelligently to help him. Knowledge is required of the applicant's family, his own role in the family group, his financial situation, and other significant environmental factors.

Educational and Vocational Evaluation

Review of the educational and vocational background of the applicant is necessary to determine whether workshop experience can be expected to contribute to his rehabilitation and to develop a constructive training or retraining plan.

Work Evaluation or Tryout

At the conclusion of the intake process, the job counselor helps determine a work tryout program for the client. A vocational counselor can provide this job counseling service as well as the placement service subsequently needed by the client. In other instances, it may be more practicable to procure job counseling from other community resources through cooperative arrangement. Job counseling must be available to the client not only after intake, but continuously during the work tryout and work conditioning and job training periods.

Work tryout reveals the client's physical capacities, learning ability, aptitudes and specific skill potential, ability to achieve and maintain adequate social relations and ability to meet the demands imposed by the work situation such as performing repetitive operations and tolerating noise and pressures. Evaluation of the client's vocational potential throughout the training period should be realistic and reflect known standards and requirements of competitive industry.

Personal Adjustment Prevocational Training

Work conditioning and training of the client should include personal adjustment training such as the development of good working habits and the ability to get along with fellow workers and supervisors. Where needed, clients should also be helped to develop adequate personal grooming, to budget their income, use public transportation and the telephone and other activities of daily living. Individual or group counseling, as well as social and recreational activities, should be undertaken by the workshop staff to enhance personal adjustment.

Work Conditioning and Training

Work conditioning and vocational training of each client must continue long enough to permit the learning of a job. For the most severely handicapped, there must be sufficient time to develop compensatory skills to permit effective performance. Therefore, duration of work conditioning will vary.

Training may be in a specific area adapted to the client's own demonstrated talents, efficiency and employment potential or may be geared to specific openings known to be available for trained workshop graduates.

Regardless of the goal, training should include instruction in the use of specifically designed tools, the proper use and care of equipment and the economical use of raw materials, training in industrial safety and sanitation, manipulative skills, muscular coordination, and grasp of concepts of time, size, shape, position, spatial relations and money value.

Job Placement

Through its own efforts, through cooperative relations with the Massachusetts Rehabilitation Commission and the Division of Employment Security, and through the development of cooperative efforts with private job placement agencies, the workshop should promote jobs and develop placement opportunities in the community.

Regular visits to help interest employers in hiring qualified handicapped applicants should be scheduled. Actual jobs should be observed to obtain first hand knowledge of job duties, the physical demands they impose, physical capacities they require, climate of the work situation, emotional strains and stresses inherent in the job, personality traits of the employer and the supervisory staff, and the production standards and methods.

Followup

Until an employment situation is well established, the counselor should be in continuous touch with the client to evaluate his progress and to make sure that a satisfactory vocational, physical and psychosocial adjustment is reached. Counselors should see that the client receives any continuing medical supervision and social casework services which he requires and should provide continuing counseling and guidance and ascertain that the client is not being exploited.

Staff members should arrange a regular schedule for periodic case review and appropriate action for clients, already placed, for clients ready for employment and for clients moving into extended employment.

Followup data regarding the adjustment of workshop clients should be maintained by every workshop as a basis for evaluating the overall effectiveness of services and the usefulness of specific service components.

SERVICES OF A COMPREHENSIVE WORKSHOP

A workshop program is one of a number of services needed by disabled persons to improve their capacity for work and life adjustment and not merely a last chance job that pays below the minimum wage. Resocialization should receive at least equal emphasis with production goals. Each workshop should have the following services available either directly or by arrangement with other agencies:

- Comprehensive evaluation (vocational, psychological, social)
- Personal adjustment training
- Prevocational and specific job training
- Suitable vocational placement, competitive and sheltered
- Followup services
- Social and recreational programs (during and after working hours)
- Individual and/or group counseling
- Supportive medical services
- Remedial education
- Habilitation training (use of public transportation, banking, budgeting)
- Classes in health, grooming and etiquette
- Improving communication skills
- Transportation

MIXED CLIENTELE

Workshops should serve a mixed clientele of mentally and physically disabled and socially disadvantaged clients. A mixed clientele makes it possible to increase the funding base, attract more qualified personnel and to enhance the workshop program. Clientele should be accepted who represent a wide range of functioning. Transitional and extended clients and day activity clients should be served within the same workshop. Although the programs may take place in separate physical areas common administrative and program staff should be utilized.

This approach can accomplish the following:

- Larger groups of disabled persons can be served.
- Program content can be enriched since disabled individuals have varying abilities permitting a wide range of work to be undertaken.
- Costs to operate the workshop can be distributed among a number of agencies whose clients utilize the services.
- Opportunities to recruit qualified staff can increase because the workshop responsibilities will be broader and offer greater challenge.
- Clients can be transported to one central location.
- Workshops can engender broader community support by providing services to many different types of clients.

At least two groupings of individuals should be included as clients of workshops. The first group includes the traditional population of handicapped persons who have a recognized disability such as the blind, deaf, physically disabled, mentally ill and mentally retarded. The second group includes handicapped persons who have been neglected such as the public offender, culturally disadvantaged, chronically disabled, aged, and the socially handicapped. Socially handicapped individuals may be further divided into the school dropout, alcoholic, narcotic addict, selective service rejectee, parolee, and chronic welfare dependent. Potential clients of the comprehensive workshop could include the following:

- The client with a long history of disability. This person has seldom, if ever, been in the working world and his past work experience is minimal.
- The client who incurs a disability and makes a rapid recovery but who, prior to his disability was an unskilled or semiskilled worker and now needs specific vocational training.
- The client who has never experienced vocational success. His life has been filled with a series of failures in establishing a vocational role and in meeting the tasks inherent in a vocational role.
- The client who, following vocational rehabilitation services, desires to upgrade himself vocationally, but is unclear as to the kind of work or position he may be capable of, or interested in.
- The young disabled client whose vocational history is meager as much because of age as because of disability.
- The vocationally disabled client who suffers from a lack of confidence and an unclear self perception of his abilities.
- The extended employment client, who is not ready for employment in the community either because of his inability to be consistent in meeting the minimum demands and requirements of a job or his inability to relate successfully to coworkers.

Workshops can play an important role in helping younger

groups of people such as the school dropout, the disadvantaged youth and the juvenile delinquent. To serve these youngsters, stimulating and interesting work, regular pay and prospects for employment in the community are a necessity. Supportive services are also required to solve the related problems of most of these youngsters.

Although a wide range of handicapped individuals can profit from workshop services, many persons with the disabilities noted above cannot receive services except in some pilot and demonstration programs. Priorities for services are usually dependent on the competence and interest of the workshop staff in working with specific disability groups and the policy set by the workshop board of directors.

A major gap exists in Massachusetts in services for the adult retardate since most services are largely child centered. Families are persuaded to keep their children at home rather than in institutions. However, when they grow up, few services exist within the community. Responsibility for adult retardates can be fulfilled by sheltered workshops teaching additional social skills. Physically and mentally handicapped could utilize the same sheltered workshop services. Workshops should be used as a major resource by the mental health-retardation centers and by the area office of the Massachusetts Rehabilitation Commission.

Although it is not feasible to stipulate similar services for every workshop, it seems likely that certain core services can be identified for all clients while certain supportive services such as medical, counseling, and recreational may be unique to persons with specific disabilities. All needed services should be made available by every workshop, either by utilizing their own staff or by contract with other agencies.

Because of the uniqueness of a multiple service workshop in Massachusetts, the effectiveness of the first workshops established should be carefully evaluated before determining the program and staffing of other area workshops. Priority for establishing workshops should be given to rural areas where no workshop services presently exist on any level.

SIZE OF WORKSHOP

Variations in the size of workshops will occur in each area based upon the types of clients requiring services, the extent of similar resources available and suitable means of transportation.

Between 150 - 200 clients should be served by a workshop providing central administration to a mixed clientele to make optimum use of diversified vocational and clinical staff.

Workshops recently introduced the concept of the satellite workshop and also the neighborhood shop to serve increasing numbers of the severely disabled. By this means, a large, well staffed, centrally located shop assigns both work and clients to shops that are more convenient to individuals experiencing difficulty commuting daily to the central facility. Satellite and neighborhood facilities prove particularly successful with the disabled aged.

FUNDING OF WORKSHOPS

Because of the wide range of clients who should be served in an area sheltered workshop, financing must come from a number of sources. Presently, the Massachusetts Rehabilitation Commission can pay for all evaluations and can fund clients in transitional workshops because of the likelihood that they will become gainfully employed. No agency has a similar responsibility for clients requiring extended employment services who do not appear capable of gainful employment. The Departments of Mental Health, Public Health, Public Welfare, and Corrections should explore the possibilities for jointly funding extended employment and day activity services for persons with severe mental and physical disabilities. Joint funding increases the amount of services purchasable and allows for better distribution throughout the state. Currently, the Departments of Mental Health and Public Health are trying to develop legal and administrative models to allow them to increase the amount of services purchased rather than to expand their own services.

Permanently handicapped persons, especially individuals with a combination of mental and physical handicaps, do not require rehabilitation but habilitation. For the most part, voluntary agencies assume the major responsibility for the enormous task of helping in the habilitation of the multiply handicapped living in the community. Additional resources are needed in the community and should be stimulated through the purchase of services with state funds.

CERTIFICATION OF WORKSHOPS

To insure uniform standards and appropriate program services for clients, all area sheltered workshops, and wherever feasible, private sheltered workshops should be certified by the Rehabilitation Facilities Board. Certification procedures should be determined by the board making full use of federal guidelines and consultation from a professional advisory committee.

POOLING SUBCONTRACTS

One of the major problems of workshops is the flow of work contracts. A number of workshops in Massachusetts operate on short term work contracts, often depending on a large contract from a single business concern. More often than not, workshops run low on subcontract work several times each month. Many workshops take on more contract work than they can realistically handle during one time period, and then during a subsequent time period have little or no work.

Approaches should be developed to overcome this fragmented and irregular procedure of work flow to sheltered workshops. The Workshop Unit of the Massachusets Rehabilitation Commission should assist the Massachusetts Chapter of the National Association of Sheltered Workshops and Homebound Programs to establish a subcontract

pool expanding a method utilized in California. This arrangement would insure an equitable, consistent flow of private and public subcontracts.

WORK CONTRACTS FROM THE COMMONWEALTH

The Commonwealth should provide workshops with a regular supply of work assignments by designating the state job orders such as printing, producing highway equipment, garment manufacturing and equipment renovation to area workshops. Arrangement should include contracting state work to be performed out of the workshop facilities. Several states including Wisconsin, California and Maryland subcontract to sheltered workshops for landscaping of state office grounds, maintenance of playgrounds and recreation sites, and state building maintenance.

PAYING THE MINIMUM WAGE

Minimum wage in the sheltered workshop is an extremely sensitive problem. By definition the workshop program functions for people who are not ready or able to enter the competitive labor market. Most workshops operate on a piece rate basis of production and the client is reimbursed based upon individual productivity. In addition, workshops find it difficult to actually simulate factory settings within their facilities.

Workshops serve as a transitional step into the community but more than 90% of all clients in workshops earn less than the minimum wage. A recent study conducted in the Commonwealth indicated that the average wage for a workshop client was about 70¢ per hour. Some professionals in the field believe that when a client approaches 75% of the minimum wage, it is time to arrange for community placement.

Specific procedures regarding the payment of wages to workshop clients is determined by the classification of the workshop. A workshop must pay at least 50% of the minimum wage unless evaluation and training services are provided for clients. If these services are provided, the workshop can pay less than one half of the minimum wage to any client placed on contract work. The majority of the workshops in Massachusetts have certificates to pay even less than half the minimum wage. By completing time and motion studies and by providing the U.S. Department of Labor, Wage and Hours and Public Contracts Division with the names of the specific clients who are seriously limited in their productive capacity, a workshop can be issued a *work activities center* certificate. Although workshops are encouraged to pay not less than 40¢ per hour, many clients are still approved at below this figure.

Unfortunately, some workshops take a portion of the reimbursement for subcontract work off the top to cover overhead and clients are further hampered in an attempt to earn a reasonable salary. Also, some workshops do not pay clients their full earnings during evaluation periods of brief one or two day tryouts.

Every effort should be made to pay clients in sheltered workshops the minimum wage, wherever possible, during evaluation, training and extended employment phases. Overhead costs and profits should not be drawn from client wages, even to expand programs. Federal and state wage subsidies to bring workshop clients up to a decent standard of living should be explored by a study committee appointed by the Commissioner of the Massachusetts Rehabilitation Commission.

SHELTERED WORKSHOPS IN RESIDENTIAL FACILITIES

Patients discharged from institutional settings have a greater chance to become independent and productive citizens if they have a vocational skill and job opportunities available to them. Recidivism is much lower for the exinstitutionalized patients who have jobs and specific training than for the nonworking discharge. This applies to institutional populations such as the physically disabled, mentally ill and mentally retarded and the public offender.

All appropriate inpatient facilities of the Department of Public Health, Mental Health, and Correction should establish and expand present sheltered workshops. These programs can serve as preliminary stages in the total vocational rehabilitation process leading to placement in competitive employment or, if needed, in a sheltered workshop when the client leaves the institution. Evaluation utilizing the vocational resources of the institution should be emphasized. Specific and realistic job stations should be provided to each person participating in the program. General work habits and specific job skills can be enhanced by this approach.

In the fall of 1967, the Department of Mental Health appointed a consultant in rehabilitation to develop workshop programs and services. As of August, 1968, there were 11 facilities with workshops and six additional facilities organized to initiate services. The Commissioner of Mental Health emphasized the value of having an evaluation, training and placement workshop service at all the facilities of the Department including state hospitals, state schools and community mental health-retardation centers.

The Departments of Public Health and Correction need to establish workshops at appropriate facilities to provide vocational evaluation, training and placement resources to their residents. By taking fuller advantage of institutional vocational resources and coordinating services, the staff of residential facilities can assist more clients toward more meaningful employment, and help them to maintain working status in the community.

COORDINATORS OF WORK TRAINING AND SHELTERED WORKSHOP PROGRAMS

To facilitate the development and comprehensive use of workshops in residential facilities and the relations between

public agencies and area workshops, the full time position of Coordinator of Workshop Training and Sheltered Workshop Programs should be established. Coordinators should be professionally trained rehabilitation workers with an administrative background in the sheltered workshop field. Positions should be established in the central office of the Departments of Public Health, Mental Health, Corrections and Education. Major responsibilities of the Coordinator should include program planning, standards, public relations, coordination of services, funding resources, and interdepartmental programming.

Additional Staff Resources

The Massachusetts Rehabilitation Commission should provide services such as program consultation, information on current planning procedures, suggestions for staffing, client services, standards and research to area and private sheltered workshops. To perform these specific functions, at least six additional staff trained in professional areas related to sheltered workshops, such as program planning, cost accounting, community relations, contract bidding, and evaluation procedures should be recruited. Staff members should be full time employees of the rehabilitation facilities section of the Massachusetts Rehabilitation Commission and maintain constant relations with all area workshops and private and institutional workshops affiliated with the Commission.

EXTENDED SHELTERED EMPLOYMENT

The 1965 Amendments to the Vocational Rehabilitation Act provided a number of opportunities for sheltered workshops to establish and/or improve upon their programs, facilities, staffing and services to handicapped clients. The workshop field has been growing slowly. Approximately one half of the present workshops in the Commonwealth function as work activity centers geared toward terminal forms of employment with salaries below the minimum wage. There is immediate need to establish a series of new sheltered workshop programs and, wherever possible, to add sheltered units to existing rehabilitation facilities.

Public and private vocational rehabilitation programs are beginning to work with more of the hard core multiply handicapped clients. Many of these clients are unable to meet the present demands of competitive employment. Depending on the future of the labor market, they may not be equipped to progress beyond the sheltered setting. Additional programs, sheltered only in terms of competition, should be established to meet this need providing therapeutic conditions to assist an individual to perform at his highest level of functioning, to be treated with dignity and respect, and to receive a meaningful wage as a productive worker.

The Massachusetts Rehabilitation Commission's Rehabilitation Facilities Unit should take the leadership in providing assistance to private organizations and other public agencies to initiate and/or improve sheltered workshop programs with the goal of serving more severely handicapped persons. Consultation should be provided on program coordination, interagency planning and referral, grant application procedures, and placement and followup techniques and resources.

Along with the Massachusetts Rehabilitation Commission, the Massachusetts Chapter of the National Association of Sheltered Workshops and Homebound Programs should take a leadership role to upgrade the services, programs and [illegible]fication of all sheltered workshops in the Commonwealth. When appropriate, agencies should be assisted to qualify as work activity centers by arranging for certification with the Department of Labor. Testimony at all public hearings sponsored by the Vocational Rehabilitation Planning Commission repeatedly indicated that several areas of the state need extended sheltered workshops including Holyoke, Pittsfield, Greenfield, New Bedford and Fall River. Construction and operation of a combination transitional extended workshop setting would enable these areas to service a greater number of presently known handicapped individuals.

Stimulating the Use of Federal Grants

A major function of the expanded Rehabilitation Facilities Unit of the Massachusetts Rehabilitation Commission should aim to assist sheltered workshops to take full advantage of the broad federal grant appropriations available through the Vocational Rehabilitation Amendments of 1965 and 1968. Workshop staff and boards of directors require assistance in developing appropriate grant applications and need to receive the latest information related to federal requirements regarding requests for construction funds, staffing, workshop improvement, and technical assistance grants. Preparation of federal grant proposals by workshops should be supported by the Massachusetts Rehabilitation Commission staff through regular consultation and guidance.

USE OF LAIRD GRANTS

Beginning in fiscal year 1966, the federal government has permitted a portion of vocational rehabilitation monies to be matched by private agency funds which are earmarked for the expansion of remodeling of buildings or the purchase of equipment at a particular rehabilitation center or sheltered workshop. This program was originally proposed by Representative Laird of Wisconsin, thus the name Laird amendment funds. The 1968 amendments to the Vocational Rehabilitation Act made the Laird amendment a permanent part of the vocational rehabilitation program and broadened the use of such funds to include new construction of rehabilitation centers and sheltered workshops.

In Massachusetts, Laird monies are only being used for the purphase of equipment to which the state retains title, although it is located at the private facility. Wider use of Laird amendment funds has not been made because of

Amendment 46 to the Massachusetts Constitution, the so-called anti-aid amendment. That amendment, in general, prohibits the use of public money or the loan of public credit to any school, hospital, institution, or educational, charitable or religious undertaking which is not publicly owned and under the exclusive control of public officers.

It has been assumed that this amendment prohibits use of Laird amendment funds for alteration or construction of buildings and also prohibits the state from allowing private facilities to obtain title to the equipment purchased.

To resolve these questions, the Massachusetts Rehabilitation Commission should seek an opinion from the Attorney General as to the constitutionality of using Laird amendment funds for the full range of permitted uses.

HOMEBOUND EMPLOYMENT

Persons whose physical or mental condition prevent them from leaving their homes regularly for education, training, rehabilitation services, employment or in pursuit of other activities are homebound. If capable of performing some work, these individuals should be provided with homebound employment. Extrapolating from population figures of the homebound group of all ages on a national scale, an estimated 26,000 persons in Massachusetts are homebound.

Vocational rehabilitation or work programs available to homebound individuals are sporadic, limited in scope and usually not organized. Many handicapped persons fortunate enough to be involved in some form of paid work are often paid below the minimum wage, and may be doing work much below their ability level. Initial problems involve the paucity of data identifying the homebound population, the number, their disabilities, background, residence and vocational potential.

People who cannot enter the labor market and are required to remain at home due to the severity of their particular disability comprise a wide spectrum of the disabled population. Therefore, no single recommendation for a program of service can be suggested to meet widely divergent needs.

Providing Work at Home Through Area Sheltered Workshops

Research reports published by the federal Rehabilitation Services Administration indicate that disabled homebound individuals can accomplish major adult functions with the support of home economics instruction, therapeutic nursing assistance, meals-on-wheels, and other supportive devices. All disabled homebound persons would profit from a central work referral service. The major focus of this service would be to provide a variety of paid work release projects to homebound persons. A central work referral service could also initiate the referral of people for vocational evaluation with the possibility of assisting people into out-of-home sheltered workshops and other people for on-the-job training programs. But, for the majority of people, the service could provide paid and realistic work to disabled homebound persons. This could include a variety of work activities such as the distribution of subcontract work and the establishment of a retail craft shop where articles made in the home are sold to the public and the profits returned to the producer.

Area sheltered workshops should provide their work referral service throughout the Commonwealth.

In most respects the vocational services required by disabled persons who cannot leave their home on a regular basis are similar to the needs of disabled persons served by the area sheltered workshop. Homebound persons who can benefit should be clients of the area sheltered workshop and should receive services. Vocational evaluations should be conducted, suitable work should be provided and necessary supportive services should be available to homebound clients.

Legal Limitations

The Industrial Home Work Law, Massachusetts General Laws, (Chapter 149, Sections 143-147) places a number of restrictions on the products which may be worked upon in the home, limits the delivery and pickup of goods to and from the home only to the employer and requires both employer and employee to have permits issued by the Department of Labor and Industries, Division of Industrial Safety.

These and related sections were put into effect to protect factory industries from undue competition and to protect the health and well being of the workers. Each of these sections should be reevaluated and changes made to permit servicing a larger group of homebound workers, to set minimum wage standards and to permit restructuring of homebound services to allow area sheltered workshops to play a major role in providing homebound employment while maintaining and strengthening employer and employee safeguards.

Role of the Area Sheltered Workshop In Homebound Employment

Homebound employment should be a part of the responsibility of each area sheltered workshop. Sub contracts with industry and other employers should be channeled through the area sheltered workshop with suitable types of work designated for the homebound. This will require changes in the present legislation (Chapter 149, Section 14[illegible]a).

At present, it is not possible to estimate the number of homebound persons who would require vocational services from area sheltered workshops. Testimony at public hearings indicated the importance of providing such services. However, area sheltered workshops will have to provide additional staff with special skills related to homebound employment, as well as appropriate administrative procedures and trucking of material to undertake such services. There is no precedent for providing homebound services within this

type of structure and newly developing models should be carefully evaluated.

Funding for homebound services should be provided jointly by those public agencies who are responsible for clients in extended employment and in day activities such as the Departments of Public Welfare, Public Health and Mental Health.

In addition to work, homebound persons are often greatly in need of other forms of help such as medical services, counseling and help with shopping. Each area workshop should assume responsibility for supportive services for homebound persons in the area directly or by referral. Staff members should routinely pay periodic visits to homebound persons to help them to get the services they urgently require.

GRADUATE TRAINING ON WORKSHOPS

Working with the handicapped in sheltered workshops requires specific professional skills and experience. Although experts differ on whether an administrator should be a rehabilitation trained director who learns business practices on the job or a business trained director who learns rehabilitation practices on the job, there is definite agreement that training in workshop administration is necessary.

University programs in the Commonwealth conducting rehabilitation training should include courses pertaining to the operation and management of comprehensive sheltered workshop facilities, such as workshop programming, evaluation, training, placement and followup and research. Courses should be scheduled for late afternoon, evenings, and if possible, Saturdays, to encourage the maximum attendance of personnel employed on a full time or part time basis.

Opportunities for workshop staff to participate in rehabilitation administration courses offered by universities allows for a greater utilization of the workshop as a valuable rehabilitating tool. Currently, the graduate program of rehabilitation administration at Northeastern University in Boston provides one of the few courses in administration of a sheltered workshop in the New England region and could serve as a model for other schools.

QUALIFICATIONS OF WORKSHOP DIRECTORS

Workshop administration is an area of professional specialization and is increasing as a segment of the rehabilitation process requiring expertise. Training should include specific university courses such as program planning, budgeting, and accounting, staff supervision, public relations, and administrative management. Supervised internship in the field is recommended.

Directors of workshops designated to provide services in an area should be required to have specific training in workshops administration and rehabilitation philosophy and procedures, regardless of their academic backgrounds. By requiring specific training, people with previous experience in areas such as business, law, manual arts, public school teaching, and psychology could qualify as workshop directors.

WORKSHOP BOARDS

Members of the board of directors of a sheltered workshop constantly review the policies and standards of the facility, and serve as a public relations representative in the community. Therefore, the board should be representative, not only of the workshop but also of the community. Citizen representation should include a cross section of the community including people from diverse educational, occupational, religious and business backgrounds.

Boards should meet on a regular basis. Workshop directors should be able to call on the skills of board members who are lawyers, engineers, plumbers, newspaper reporters, housewives, university professors, union members, and should be able to call on local citizens for consultation.

EDUCATIONAL OPPORTUNITIES

Rehabilitation should provide disabled persons with the necessary skills and emotional and environmental supports to attain their optimum level of functioning. Most of the preparation readies an individual for a semiskilled or unskilled job by developing his physical rather than his mental capacities. An effort should always be made to explore both physical and mental attributes as resources for vocational rehabilitation and clients should be given an opportunity to attend technical schools and institutions of higher education to develop vocational skills.

The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should initiate and expand their relations with institutions providing specialized training and higher education. Inservice training programs at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should stress educational and technical training as an important direction for vocational rehabilitation for certain clients.

Use of Vocational High Schools

Facilities and equipment of public and private vocational high schools are an excellent educational and training resource for handicapped youths and adults. Area rehabilitation directors and the local school committees should make arrangements for the use of these facilities. Whenever possible, programs should be conducted during regular school hours. Evening, weekend and summer schedules should also be developed to make maximum use of vocational high schools as a component of community rehabilitation services.

When feasible, teachers from the schools or personnel from area workshops should be hired to teach the handicapped persons. The area director of the Massachusetts Re-

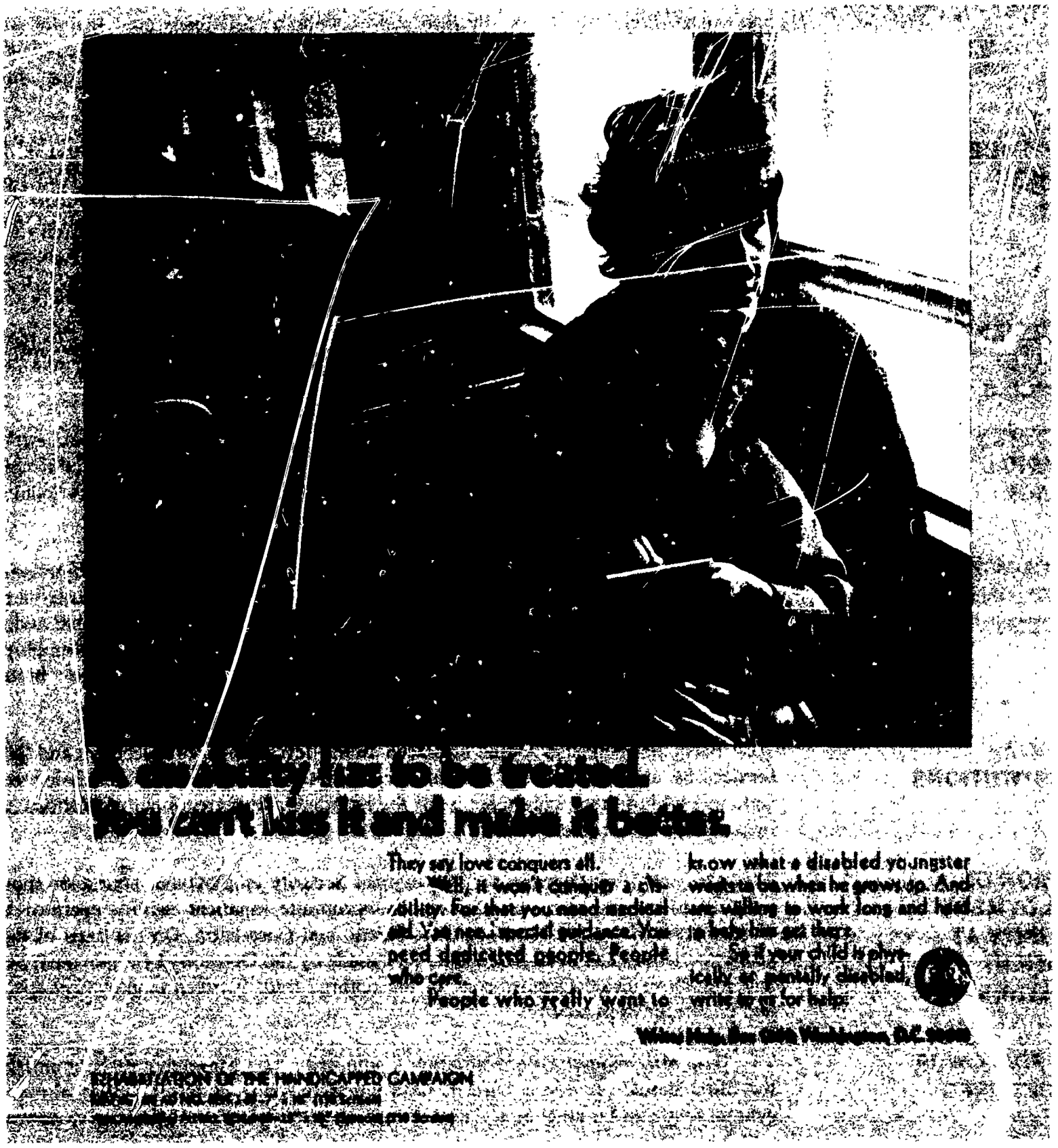
habilitation Commission should provide specialized training in the goals and techniques of teaching vocational skills to handicapped persons.

GOVERNOR'S COMMISSION ON HIGHER EDUCATION FOR THE HANDICAPPED

Only a small number of public and private colleges and universities are prepared to enroll disabled students by having accessible dormitories, dining halls, and access to recreational and social activities. Many more qualified disabled persons could avail themselves of technical and professional education if all parties concerned would get together to develop plans and procedures for eliminating the obstacles which at present exclude disabled persons from most institutions of higher learning.

A temporary Governor's commission on higher education for the handicapped should be appointed for this purpose.

The Commission should represent administrators and teachers from technical, undergraduate and professional schools; the Massachusetts Department of Education; the Massachusetts Board of Higher Education; the Massachusetts Rehabilitation Commission; the Massachusetts Commission for the Blind; the Massachusetts Commission on Employment of the Handicapped, and disabled persons who have undertaken post high school education or are professional educators.



PROVIDING VOCATIONAL PLACEMENT AND FOLLOWUP SERVICES

RECOMMENDATIONS

SERVICES FOR ALL HANDICAPPED PERSONS

70. Suitable vocational placement and followup services should be provided to all handicapped persons after receiving appropriate vocational evaluation.

The Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security should be the public agencies responsible for providing these services.

NEW INTERAGENCY AGREEMENT FOR PLACEMENT SERVICES

71. A new cooperative agreement should be drawn between the Division of Employment Security, the Massachusetts Rehabilitation Commission, and the Massachusetts Commission for the Blind to facilitate the successful employment of handicapped persons. The agreement should emphasize the procedures to help individuals enter gainful work at levels commensurate with their potential capacities and skills, contact with social agencies and employers and an acknowledged responsibility for followup services with clients after vocational placements are secured.

USE OF JOB LISTINGS

72. The proposed cooperative agreement between the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security should include a provision that Division of Employment Security job listings will be made available to area offices of the Massachusetts Rehabilitation Commission. This provision should specify that the Massachusetts Rehabilitation Commission will approach employers after first consulting with the Division of Employment Security.

PLACEMENT BY PRIVATE AGENCIES

73. Community social agencies attempting to place handicapped clients in employment should contact the Massachusetts Rehabilitation Commission office in their area to make use of job listings and to obtain other placement assistance.

PLACEMENT REFERRAL SERVICE

74. Each area office of the Massachusetts Rehabilitation Commission should establish a direct placement service with the primary function of providing advice and information to disabled clients whose preliminary evaluation suggests they only need vocational placement.

NONCOMPETITIVE VOCATIONAL PLACEMENTS

75. The Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security should develop alternative forms of vocational placement for handicapped persons such as hard core unemployed, and multiply and severely handicapped clients who are not able to work at competitive employment. Transitional and extended sheltered workshops, work study programs, on-the-job training, and homebound employment should be made available to these persons.

SERVICES IN INSTITUTIONS

76. Particular emphasis should be placed on the development of placement and followup services by appropriate state chronic care hospitals, mental health-retardation centers, state mental hospitals, state schools for the retarded, and correctional institutions, staffed by professionally trained workers.

DIVISION OF EMPLOYMENT SECURITY AT INPATIENT FACILITIES

77 One full time Division of Employment Security employment counselor should be assigned for a one year period to each appropriate inpatient facility operated by the Departments of Mental Health, Public Health and Correction. On the basis of that one year experience, a determination should be made by the Division of Employment Security and the above listed Departments, of the optimal ratio between employment specialists and clients for each facility.

NEW FOLLOWUP PROCEDURES

78. The Massachusetts Rehabilitation Commission and Massachusetts Commission for the Blind should provide at least 90 days intensive followup and 9 additional months of general followup for all clients placed in employment regardless of the case closure date.

PURCHASE OF PLACEMENT SERVICES

79. Purchase of placement and followup services from private agencies should be increased by the Massachusetts Rehabilitation Commission. Private agencies and workshops should actively seek such contractual agreements.

PROFESSIONAL TRAINING IN PLACEMENT AND FOLLOWUP

80. Rehabilitation personnel in public and private agencies providing vocational placement and followup services should have specialized training in employer contact, job requirements, job placement techniques, the psychology of occupations, and followup procedures.

INSTITUTES ON PLACEMENT AND FOLLOWUP

81. Institutes on current placement and followup procedures should be conducted for students and agency personnel by university rehabilitation programs. Grants and stipends for such institutes should be increased by the Rehabilitation Services Administration.

PROFESSIONAL CONSULTING TEAMS

82. Professional consulting teams should be available from the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security to consult with professionals in public and private agencies and with personnel from business and industry about the principles of placement and followup.

REHABILITATION ASSISTANTS

83. A demonstration project to determine how rehabilitation counselor assistants can assist counselors in the placement and followup process should be initiated by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind. The assistants should be utilized to assist in responsibilities such as contacting employers, getting clients job interviews, followup on the job, and securing transportation under close supervision of trained personnel.

MASSACHUSETTS COMMISSION ON EMPLOYMENT OF THE HANDICAPPED

84. To expand working agreements between industry and vocational rehabilitation agencies, the Massachusetts Commission on Employment of the Handicapped should be given additional funds and staff to augment and expand its programs of promoting job placement. Local units of the Commission should expand and intensify efforts within smaller geographic boundaries.

RESEARCH ON THE PLACEMENT PROCESS

85. Research units of the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind and the Division of Employment Security should conduct or support studies and demonstrations to determine the most effective and efficient practical procedures to accomplish placement and followup of handicapped clients.

RESEARCH ON ATTITUDES TOWARD EMPLOYMENT OF THE HANDICAPPED

86. Studies should be periodically undertaken to determine attitudes toward the employment of handicapped individuals. The Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Division of Employment Security, and the Massachusetts Commission on Employment of the Handicapped should assume joint responsibility for the support of such studies.

SERVICES FOR ALL HANDICAPPED PERSONS

A basic point of view in the field of vocational rehabilitation is that handicapped persons have assets as well as limitations which should be utilized to help them in their overall adjustment. The fullest use should be made of the individual's untapped and undeveloped capacities as a means of countering the effects of his handicap.

Placement in employment should not be influenced by charity or pity, but should be determined by the specific abilities of the handicapped individual to work just as abilities determine the work of the non-handicapped person.

At the same time, it is important to remember that handicapped persons do encounter certain problems attempting to locate employment. Handicapped persons, such as the blind or those in wheel chairs or on braces or crutches, experience transportation difficulties and general problems with mobility. Others are faced with an omnipresent negative attitude, especially the mentally ill, the epileptic or the ex-offender. Mentally retarded individuals are often unprepared to accomplish a vocational role and other common adult tasks, and may function as social isolates. The culturally deprived may lack the basic educational skills required for all but the most menial jobs. Many rehabilitated individuals require continuous supportive care such as the epileptic person needing medication to prevent seizures, the mentally ill per-

son involved in psychotherapy and the paraplegic requiring prosthetic maintanance.

To be able to take advantage of the available employment opportunities, handicapped persons need specific and individual job placement services and attention going beyond job placement systems operating for the non-handicapped.

PRESENT PATHWAYS TO EMPLOYMENT

Nonhandicapped persons are able to utilize a number of different channels to enter the labor market such as informal referrals, private employment agencies, newspaper ads and union listings. These channels are not always open to handicapped persons due to a variety of barriers related to transportation and mobility, negative public attitudes and the inability of agencies to service individuals with a disability.

Informal Channels

Many persons utilize informal procedures and assume the responsibility for getting a job themselves or receive assistance from family, friends, or neighbors. Many families, friends and neighbors of handicapped persons are unable to provide assistance to locate a job because they are uncertain about the individual's job capabilities and the degree of limitation involved due to the specific handicap. Often, dependency is encouraged and handicapped individuals are offered positions well below their capacity. Another problem arises from the fact that a handicapped person's potential is not easily identified by well meaning family and friends. Latent abilities might not be perceived. In addition, family and friends may not know about placement resources and job openings available to handicapped persons. A need exists for organized and easily identifiable resources and services for handicapped people to enter the labor market.

Private Employment Agencies

Nonhandicapped individuals often use private employment agencies to locate a position and pay a fee for their service. Handicapped persons experience significant barriers and problems when they attempt to utilize private employment agencies. Due to lack of funds, the fee for service may prevent a handicapped individual from approaching a private employment agency. In addition, few private agencies are equipped to assist handicapped people in locating appropriate jobs because they do not understand the dynamics of disability, cannot assess the specific assets and liabilities of the applicant and are fearful of sending a handicapped client to their regular list of feepaying employers.

Public Employment Agencies

The programs and services of the Division of Employment Security, the public employment agency, are available to citizens throughout the Commonwealth. Although the Division of Employment Security does have a special unit to provide service to handicapped applicants, the Division is not equipped to find employment for more than a small percentage of all handicapped applicants. Staff persons frequently do not have any training in the placement of handicapped persons, and thus may fear a client who presents anything but a minimal problem situation. Professional skills of counselors need upgrading to enable the Division to serve more and varying groups of handicapped people. The usual employer contacts need to be broadened to tailor individual job requirements to the needs of particular applicants. Since the Division of Employment Security is overloaded by the numbers of nonhandicapped applicants who require service, an increased staff will be required to assist handicapped clients in locating employment.

Other public agencies within the Commonwealth have the responsibility to assist handicapped clients in locating and attaining successful job placement including the Departments of Correction, Public Welfare, Mental Health, Public Health, the Commission for the Blind, the Commission of Probation, the Parole Board and various anti-poverty agencies. Although these agencies attempt to rehabilitate and restore all their clients, they are often unable to provide job placement due to limited staff and resources. Written agreements between these agencies and the Massachusetts Rehabilitation Commission are non-existent or limited in scope and use. Even within agencies established to help the handicapped there is a necessity to establish specific programs, agreements and supportive aids related to job placement.

Business and Industrial Firms

Business and industrial firms utilize their own personnel departments to interview and hire applicants, relying heavily upon newspaper advertisements. As is common in other settings, the staff of the personnel departments are not able to evaluate the capabilities of the handicapped applicant and are unsure about the effects on other employees or their customers toward their employment of a handicapped worker. Also, many handicapped individuals hesitate to apply and be interviewed by themselves. Handicapped persons may desire and need assistance and support by a trained professional when they apply for a job or respond to a newspaper ad.

Private Placement Bureaus

Placement bureaus are located in a variety of settings. Unions maintain job listings for the use of both old and new members, for example, truckers, carpenters, and waiters. Associations and professional organizations such as nurses and engineers, assist their members in locating positions. Universities operate placement bureaus for their graduates. Religious, fraternal and social organizations provide various forms of job assistance to their members. However, these agencies are not equipped to evaluate the handicapped indi-

vidual's potential and to translate the data into meaningful referrals. As is evident in the utilization of other job placement procedures and resources, a need exists for special services for the handicapped beyond the existing programs for the nonhandicapped.

Private and Voluntary Nonprofit Organizations

Currently, more than 40 sheltered workshops plus other private organizations operate in Massachusetts working for the benefit of handicapped persons. Most of these agencies work with only one selected disability group or handicapping condition such as the mentally retarded or mentally ill. Therefore, some handicapped individuals receive evaluation, training, and placement services, but only if they have the specific handicap served by the agency. Many others who need services may not receive any attention or may not become involved in any programs leading to eventual job placement because no agency in their location specializes in their type of handicap.

Hospitals and Clinics

Public, private and university affiliated hospitals and clinics provide limited vocational placement assistance to handicapped people as part of their treatment program. However, emphasis is not upon vocational placement, but rather on diagnosis and restoration. An increased use of cooperative agreements and referral procedures to agencies such as the Massachusetts Rehabilitation Commission is needed to provide specific job evaluation, training and placement assistance.

THE CHALLENGE

A primary need exists to develop a framework to provide vocational placement and followup assistance to all handicapped citizens in the Commonwealth requiring this special service. Lacking are a sufficient number of programs and staff to provide assistance at the local level to all people presently known to require services. Present operating pathways to employment cannot identify all those in need of job placement services nor adequately organize individual job placement opportunities for all clients in the system. Therefore, any local area system organized to provide continuous comprehensive vocational rehabilitation services should include job placement and followup assistance to all clients.

DEFINITIONS

Vocational placement refers to the procedures used to assist an individual to enter gainful occupation, at a level commensurate with his maximum level of potential and in line with his capacities and skills. A variety of placements are included such as self employment, competitive industry, sheltered workshops, transitional work programs, homebound programs, volunteer work, temporary job tryout and functioning as a homemaker.

Followup is an integral facet of vocational placement in terms of the continuity of vocational rehabilitation services provided to a client aimed at assisting him to maintain his gains. Procedures should be varied and should include problem solving with client and employer on the job, contact with the client on a regular basis, contact with the client's family and the employer on a regular basis. Counselors should be available to employees who require assistance to handle specific problem situations even some time after they have been placed in employment. More important than any specific form of followup is an acknowledged responsibility and commitment to the client that rehabilitation services will be ongoing and consistent.

NEW INTERAGENCY AGREEMENT FOR PLACEMENT SERVICES

In order to make available the most comprehensive placement resources for the successful employment of handicapped persons, the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security should draft new cooperative agreements. At present, the Division has written procedures to organize the transfer of clients to the Massachusetts Rehabilitation Commission, and to service clients referred to them by the Commission. These arrangements should be carefully studied and amended to strengthen the procedures utilized and to allow for a sharing of job placement information and resources between counselors from both agencies. When situations occur where both agencies provide services to an individual client, recognition and appropriate credit should be given to both. Wherever appropriate, aspects of the new cooperative agreement should include clients from the Massachusetts Commission for the Blind.

These new agreements will have special impact in certain geographical areas of the state where few resources are currently available. For example, staff from each of the three agencies would be able to share offices, clerical help and telephones in rural areas and communities where public transportation is minimal.

A client of the Division should be able to become a client of the Commission and visa versa without unnecessary redtape. The client should have a letter of introduction, preceded by a telephone call between counselors of the respective agencies. Immediate appointments should be scheduled with ready access to case history data provided by the referring counselor. In order to insure continuity of service, feedback information about the disposition of the client should be provided to the original source of referral.

The agency that accepts the referral should be responsible for utilizing all available resources to accomplish a meaningful job placement for the client, and also to provide followup services.

USE OF JOB LISTINGS

Job placement listings and resources of the Division of Employment Security should be made available to more handicapped citizens on a local area basis. The Division operates 53 offices throughout the Commonwealth offering a range of services including job appraisal, job placement, and job followup.

The Division compiles, on a regular basis, an extensive listing of job openings and employer contacts. These listings are made available to their local offices in the appropriate geographical areas. The proposed new cooperative agreements between the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security should include a provision which makes available the Division's job listings to area offices of the Massachusetts Rehabilitation Commission. To insure a professional relationship with cooperating employers, Commission staff should consult with Division of Employment Security staff prior to contacting an employer. Considering the diversity of occupational skills of the Massachusetts Rehabilitation Commission clients, this additional job resource channel will enable counselors to place clients in specific jobs commensurate with their interests, capacities and potential.

Every means should be used to insure employer confidentiality and Massachusetts Rehabilitation Commission staff should work through Division of Employment Security staff who have established positive working relationships with the employers.

PLACEMENT BY PRIVATE AGENCIES

Private agencies, many of whom provide service to clients from the Massachusetts Rehabilitation Commission, should collaborate with the Commission to provide the best job placement resources possible to their clients. Certified private agencies should arrange to have their professional staff contact Massachusetts Rehabilitation Commission counselors to utilize job listings and receive other kinds of placement assistance such as current information and research in the area of placement and followup. When a private agency counselor is provided with information from job listings, the approach to a prospective employer should be cleared through the local Massachusetts Rehabilitation Commission office, always respecting employer confidentiality. As a result of this cooperation, each area office of the Massachusetts Rehabilitation Commission will be able to expand their job placement endeavors through the appropriate use of local community private agencies.

PLACEMENT REFERRAL SERVICE

Many handicapped people who have been evaluated only require assistance in locating a specific job. Preliminary work by professional staff may indicate that further comprehensive evaluation is not necessary and there are no recommendations presented for restorative or vocational training services. When this occurs, each area office of the Massachusetts Rehabilitation Commission should be equipped with adequate information, liaison relations, and vocational resources to provide appropriate advice and information to handicapped clients only requiring vocational placement.

Timeliness and readiness to assist the handicapped client are two important factors. The handicapped person, who may have little or no residual handicapping condition, should be serviced as soon as possible following application. The motivation to be placed into employment should not be reduced by unnecessary paper-work or uncalled for additional evaluations. This would be facilitated by the establishment of "direct placement referral services" at each area office of the Massachusetts Rehabilitation Commission.

NONCOMPETITIVE VOCATIONAL PLACEMENTS

Provision of comprehensive vocational rehabilitation services to a handicapped client may be measured in terms of a variety of beneficial gains. Certainly, two basic aspects should be included: the client's adjustment and ability to function independently at life tasks, and his progress and readiness to enter some form of gainful occupation. What forms should placement take? What alternatives to competitive employment should receive additional attention?

Private vocational rehabilitation agencies, the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Division of Employment Security should investigate ways to make greater use of alternate forms of vocational placement other than full-time competitive employment. Consideration should be given to at least five other forms of employment which provide significant potential opportunities for gainful occupation of the rehabilitated client:

- Transitional placement such as in a sheltered workshop, eventually leading to full or part-time competitive employment in the community.
- Work-study programs for the disabled adolescent and disabled young adult with an opportunity to continue academic and trade studies part of the day, and to spend part of the day in a realistic paid industrial situation. This can also serve as a preparatory, transitional stage employment.
- On-the-job training requiring organized arrangements with specific industries and businesses to provide vocational opportunities where clients can learn selected skills while receiving a salary.
- Homebound programs serving as a form of remunerative employment for clients whose level of functioning does not allow them to leave their home.
- Extended sheltered employment for clients whose potential and productivity is below the level required for any form of competitive employment.

SERVICES IN INSTITUTIONS

State hospitals, state schools for the retarded, community mental health-retardation centers and all correctional institutions should establish and maintain their own vocational rehabilitation programs, including placement and followup services staffed by professionally trained workers. These vocational rehabilitation programs should be related to similar services being performed by the Massachusetts Rehabilitation Commission and the Division of Employment Security to help close existing gaps in training and placement and followup services.

Vocational Rehabilitation in State Hospitals

Several state hospitals in Massachusetts have experimented with the use of inhospital vocational training programs and community placement services. At times, the results of these programs have been dramatic. A rehabilitation program at Medfield State Hospital worked with a randomly selected group of 140 chronic patients with an average length of hospitalization of 12.6 years. More than 45% of the patients returned to jobs in the community during the first 2½ years of the program's operation. During the first year of operation of a central employment office designed to evaluate and train patients in hospital industries, more than ⅓ of the patients involved at Boston State Hospital were placed in jobs in the community. Most of these rehabilitation projects are sponsored by federal grants from the National Institute of Mental Health and the Rehabilitation Services Administration with little financial or staff support from the state Department of Mental Health. Of the 18 state institutions, only six have any form of vocational rehabilitation program, with four providing specific vocational placement services to patients being discharged. Together the rehabilitation staff accomplishes the vocational placement of less than 800 patients per year, a small percent of the Commonwealth's inhospital population. If only one-half to one-third of the patients in hospitals need this assistance, the necessary minimum of staff is still far short.

Division of Employment Security Counselors at Inpatient Facilities

To make placement and followup services available to handicapped citizens, the Division of Employment Security's administrative staff should assign employment counselors to chronic disease hospitals, mental hospitals, state schools for the retarded, courts, and correctional institutions. Assigned staff persons should be provided with necessary clerical aid, space and supplies. In addition, the staff should be encouraged and assisted in every way possible to identify with the assigned agency as an important consultant member of their staff rather than an outsider. The best procedure would be the assignment of Division of Employment Security staff four days a week to another agency and one day at their central office. Results of a recent pilot program conducted by the Division of Employment Security at Boston State Hospital demonstrated the value of a senior employment counselor working with hospital staff. Operating within the framework of the hospital rehabilitation department on a one day a week basis, the employment counselor was able to assist between three and twelve long term institutionalized mentally ill clients on a daily basis, to enter into job training or job placement in the community.

The Division should assign at least one full-time employment counselor to all appropriate inpatient facilities operated by the Departments of Mental Health, Public Health, and Correction for a one-year period. On the basis of that experience, a determination should be made by the Division of Employment Security and the above listed Departments of the optimal ratio between employment counselors and clients for each facility.

NEW FOLLOWUP PROCEDURES

Currently, federal regulations require a case to be closed a minimum of 30 days after the handicapped person is placed on a job. However, lengthened followup procedures are often required to help clients retain their self confidence and to overcome unexpected obstacles in their vocational adjustment. All clients placed in employment by the Massachusetts Rehabilitation Commission should receive two phases of followup regardless of the closure procedure established by the federal government. In practice, the case closure statistics reported to the federal government need not be affected by the proposed followup procedures recommended for the state program.

Revised followup procedures should include an initial intensive 90 day followup to assist the client to adjust to the demands and requirements of the job. At the end of this time period, a general followup plan should be organized for an additional nine months.

All private and public agencies having contracts to serve Massachusetts Rehabilitation Commission clients should be required to establish this one year followup procedure. Similar followup procedures should be developed by other agencies for their clients placed in employment.

A large number of clients placed in various kinds of employment receive limited and often very brief forms of followup contact. Contact with the employer and the client is sporadic and usually dependent on the schedule of the staff member who made the original vocational placement. Procedures should be developed by the Massachusetts Rehabilitation Commission for contractual arrangements with designated private agencies to assume followup responsibility for Commission clients wherever it is not possible for the Commission to do the followup. In these situations, the Massachusetts Rehabilitation Commission staff should coordinate the 90 days intensive plan and the nine month general plan.

To accomplish a consistent followup plan, new followup units with additional personnel should be established in all central and local offices of the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind and the Division of Employment Security. Professional lit-

erature varies as to the positive and negative effects of shifting a client from one professional worker to another. However, the reality of the situation suggests that it is necessary to consider an alternate to present followup procedures which often will not provide more than an occasional visit or telephone call during the first 30 days of employment.

PURCHASE OF PLACEMENT SERVICES

More than 40 private workshops and other non-profit agencies throughout the Commonwealth provide handicapped clients with some form of vocational placement services. Services include placement into competitive employment, assistance in locating job opportunities, and providing specific job information. These private agencies generally serve one or more specific disability groups or handicapping conditions with almost every type of handicap served by at least one private agency. Unfortunately, however, the specific agency may be located at a great distance from the disabled client in need of assistance. Deaf persons can only receive evaluation, training and initial placement contacts at an agency located in Boston. Only in Boston or Springfield can a client with epilepsy get an evaluation and job information. With the paucity of public agencies and programs providing services to handicapped persons, private agencies should be more fully utilized to provide vocational placement and followup assistance.

Placement is one of the required services to be provided under the federal Vocational Rehabilitation Act. The law states that, "the state plan shall provide that the state or local rehabilitation agency will assume responsibility for placement of individuals accepted for service." Flexible interpretation of the phrase "assume responsibility" would allow the Massachusetts Rehabilitation Commission to utilize any and all private facilities to accomplish the placement objective. Partly because of the Massachusetts Rehabilitation Commission's need to maintain statistical data on clients served and rehabilitated into employment, the Commission has acted as both the referring agent and the placement agent. Actually, when a private agency does contract with the Massachusetts Rehabilitation Commission to provide personal adjustment and/or work adjustment services to a client, the private agency often does the job placement, with the Massachusetts Rehabilitation Commission receiving placement credit.

Massachusetts Rehabilitation Commission should contract with all capable private agencies and workshops within the Commonwealth to provide job placement and followup services to clients. Credit for successful placements can still be retained by the Massachusetts Rehabilitation Commission.

PROFESSIONAL TRAINING IN PLACEMENT AND FOLLOWUP

To insure the successful rehabilitation of a client, the staff member responsible for providing placement and followup services must be appropriately trained. Training should include a sufficient number of courses dealing with the world of work, use of community resources, job placement techniques and followup procedures for handicapped clients.

Whenever a staff member is assigned responsibilities in the placement and followup area not closely related to his field of graduate training, he should be required to undertake specific training in university programs, on agency funds and during working hours. Public agency staff presently providing placement and followup assistance to handicapped clients should be required to meet minimum academic requirements if they do not have a graduate degree. Private agencies serving Massachusetts Rehabilitation Commission and the Division of Employment Security clients should be required to arrange for necessary inservice training of their staff.

INSTITUTES ON PLACEMENT AND FOLLOWUP

Institutes on current placement and followup procedures should be conducted for students and agency personnel by university rehabilitation programs. At the present time the rehabilitation counselor training programs at Boston University and Springfield College and the rehabilitation administration training program at Northeastern University offer evening courses in placement and followup techniques for handicapped persons. Public and private agencies should investigate methods of securing federal and state monies to organize inservice training and to sponsor academic training in these subjects at the universities. Grants and stipends for such training should be increased by the Rehabilitation Services Administration.

PROFESSIONAL CONSULTING TEAMS

Professional consulting teams composed of specialists in the area of vocational placement and followup should be available on a regular basis to public and private agency staff to conduct inservice training, seminars, and institutes. Funds for the establishment of these teams should be requested from the federal Rehabilitation Services Administration by the Massachusetts Rehabilitation Commission.

Staff from the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Division of Employment Security, and university training programs should jointly develop appropriate inservice training programs and educational materials for at least two groups: the professionals in public and private vocational rehabilitation agencies responsible for placement and followup, and the personnel from business and industry who will be accepting rehabilitated workers.

With the constant flux in the job market, the variety of job skills which can be contained in a training program, and the often sudden overhauling of major industries, professionals responsible for the placement and followup of rehabilitated clients require current information and knowledge.

The consulting teams should organize regular short-term training programs and half-day sessions with public and private agency staff.

At the same time, professional consulting teams should be in regular contact with business, industry and labor to alert these sectors of society to the labor pool of rehabilitated clients, often well-trained, which is available to them. Current information and advice should be provided regarding the potential of clients recommended by certified agencies, and procedures should be suggested to utilize these employees most effectively.

Consulting teams should serve as a valuable bridge between the agencies training and placing disabled clients and the companies receiving these workers, and support both groups to accomplish more effective communication and relationships.

REHABILITATION ASSISTANTS

Rehabilitation assistants are another resource in providing comprehensive vocational placement and followup services to the handicapped. Many states including Oklahoma, California, New York and Vermont have had success in the use of rehabilitation assistants, especially in organizing and providing placement and followup services. Rehabilitation assistants can locate job opportunities, escort clients to interviews, handle on the job problems and perform other types of assistant roles helpful to professional staff.

The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should conduct an intensive demonstration in the utilization of rehabilitation assistants to determine the potential gains to be realized. Assistants should be given every opportunity and encouragement to receive graduate training and thus become eligible to move into professional staff roles.

MASSACHUSETTS COMMISSION ON EMPLOYMENT OF THE HANDICAPPED

Although the Massachusetts Commission on Employment of the Handicapped was established by Chapter 662, Acts of 1958, the Commission has been restricted in its activities because no staff is available and only nominal funds have been appropriated to carry out the Commission's functions. The Commission consists of representatives from 11 state agencies providing services to handicapped persons plus sixteen private citizens appointed by the Governor. Functions designated for the Commission include the promotion of employment opportunities for the handicapped, cooperation with all agencies responsible for the rehabilitation and employment of the handicapped, and the development of local committees to work on these objectives.

Much more intensive efforts are needed if the Commission is to even come close to achieving its functions as set forth in the law. It is imperative that funds be appropriated and that staff persons be assigned to work for the Commission. Representatives of the various Commissioners who are chosen to serve on the Commission should be able to devote time and energy toward its activities. Certainly, with leaders of industry and labor serving on the Commission, progressive directions could be chartered. Local units of the Commission should be established within smaller areas as provided for in the original legislation. Community businessmen would then be able to participate actively within geographic areas that they know intimately. Local units of the Commission should work with employers in their area, provide information and resources, coordinate job placement opportunities and intensify efforts to hire the handicapped.

RESEARCH ON THE PLACEMENT PROCESS

Systematic study and evaluation of placement and followup procedures should be an integral part of comprehensive planning for handicapped persons. Organized research and demonstration projects operated by public and private agencies are necessary to identify appropriate and practical techniques to facilitate vocational placement and to establish meaningful followup systems. Research is needed in a number of areas including, physical and psychological barriers to employment of the handicapped; types of employers most receptive to employing the handicapped; techniques to overcome the negative attitude of employers; roles to be played by organized labor, the state and federal governments; and the attitudes of the legislature towards tax benefits for increasing employment of the handicapped. Data of this nature will greatly assist the public and private agency to determine their involvement and participation in providing placement and followup services.

There is need to study and evaluate the present placement and followup services provided by public and private vocational rehabilitation agencies. Little is known about the procedures and operational problems experienced by these agencies. Several private agencies have professional staff to organize and carry through research projects. Graduate training programs at Boston University, Northeastern University and Springfield College, all specializing in the preparation of rehabilitation workers, would be appropriate agencies to conduct research and demonstration projects.

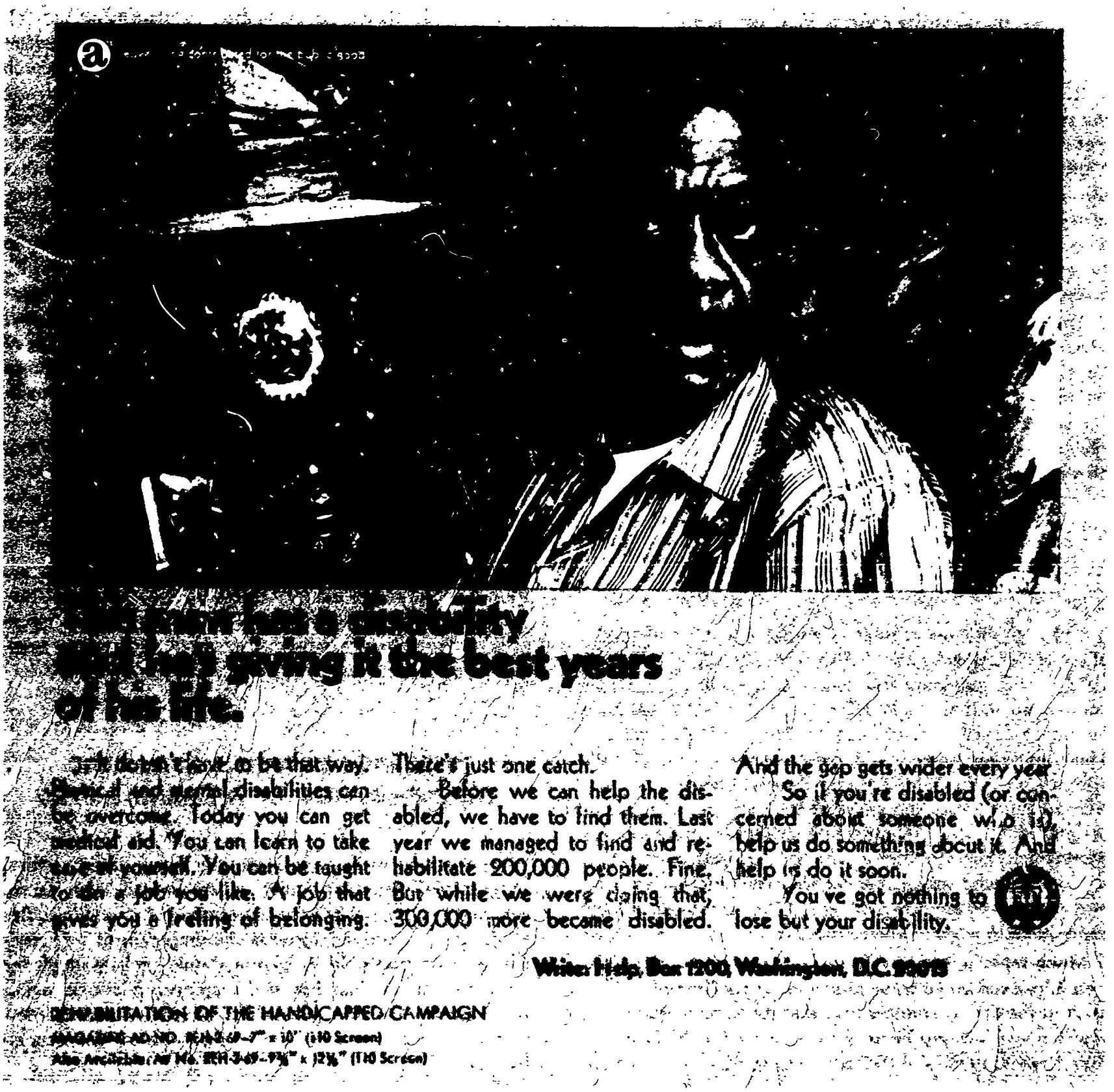
RESEARCH ON ATTITUDES TOWARD THE EMPLOYMENT OF THE HANDICAPPED

Involvement of business leaders in rehabilitation efforts suggests that many companies and individuals might be receptive to individual or joint sponsorship of research studies to determine attitudes towards the employment of handicapped individuals. Investigation should include employer attitudes, foreman-handicapped employee relations, union involvement, industry expectations of rehabilitation professionals in placing clients, and followup procedures desired by industry.

RESEARCH ON PLACEMENT IN NONCOMPETITIVE EMPLOYMENT

A sizeable number of handicapped persons are not able to meet the demands and requirements of competitive employment. Research is needed to answer questions concerning what kinds of noncompetitive employment programs are necessary, how many are needed, where they should be located, and how they should be staffed and financed. At present, placement programs include transitional and extended sheltered workshops, homebound programs and other forms of non-competitive employment. An attempt should be made to identify, categorize, evaluate, coordinate and upgrade these programs into a meaningful network of services available to handicapped clients.

Federal Social and Rehabilitation Service grant appropriations are available to conduct research and demonstration projects in the area of placement and followup. Other federal agencies having responsibilities in this field, such as the National Institutes of Health, the National Institute of Mental Health, the Office of Economic Opportunity, and the Department of Labor also have research funds available. The Massachusetts Rehabilitation Commission should assist other public and private agencies to apply for federal funds and for other monies available from grants from the Commonwealth. Also, private industry should be approached and involved in sponsoring appropriate research and demonstration studies in this area.



REMOVING ARCHITECTURAL BARRIERS

RECOMMENDATIONS

COMMUNICATING THE PROBLEM

87. Public officials, architects, builders, medical and allied health professionals, educators, community groups, and the communications media should help direct public attention and public policy to the removal of architectural barriers which present obstacles to the employment, training, education and functioning of handicapped persons in the community.

Toward Improved Building Design

INCORPORATING MINIMUM SPECIFICATIONS

88. The *Specifications for Making Buildings and Facilities Accessible to and Usable By Physically Handicapped Persons* of the United States of America Standards Institute should be incorporated in the design and construction of all new buildings generally open to the public. Existing buildings used by the public should be renovated to meet the following minimum principal specifications drawn from the USASI Specifications:

- One prominent ground level or ramped entrance.
- Elevators from the entrance level to all floors.
- Nonslip floors of a common level or ramped throughout.
- Doors and corridors wide enough for wheelchairs.
- One booth in restrooms large enough for a wheelchair.

LEADERSHIP FOR REMOVING BARRIERS

89. To carry out its legislative mandate, the newly established architectural barriers board should develop specifications for the elimination of barriers from all public buildings.

In addition, the board should assume leadership in directing the efforts of relevant public agencies, professional associations, and building trades groups towards the goal of eliminating architectural barriers from all buildings generally open to the public.

LEGISLATION TO EXTEND BOARD JURISDICTION

90. Legislation should be enacted establishing the permanent full time position of executive secretary to the architectural barriers board. Qualifications for this position should include experience in state government, construction, and architecture.

Secretarial, clerical and technical staff to assist the executive secretary in the work of the board should also be provided.

UNIFORM BUILDING CODE

91. Jurisdiction of the architectural barriers board should be extended to include all places generally open to the public such as office buildings, stores, educational, recreational and cultural facilities, mass transportation facilities, and places of worship.

ACCESSIBILITY TO ALL SCHOOLS

92. Any uniform building code drawn up for Massachusetts should include appropriate sections of the United States of America Standards Institute's specifications.

Education and Training Facilities

UNIVERSITY PROGRAM FOR SEVERELY DISABLED STUDENTS

93. All private and public educational and training facilities should accommodate physically disabled students. School and college buildings should be designed or modified in accordance with the United States of America Standards Institute's specifications.

On campus transportation usable by the physically handicapped should be provided where the buildings are scattered over large areas or on hilly land.

PUBLIC HOUSING AND HOUSING FOR THE ELDERLY

94. An office for handicapped students should be established at the University of Massachusetts at Boston to develop at home and in hospital educational programs for severely disabled students, provide and coordinate services for disabled students both on and off campus, and participate in the planning of barrier free facilities.

Barrier Free Housing

SPECIALIZED HOUSING FOR THE SEVERELY DISABLED

95. All new public housing and housing for the elderly throughout the state should be made usable by the physically handicapped, by incorporating the United States of America Standards Institute's specifications. Where the building height does not justify the expense of an elevator, the entrance to the building and the apartments on the ground floor should be free of architectural barriers.

TRANSPORTATION RESEARCH

96. Multiunit, low rent apartment housing for severely physically disabled individuals and their families, as well as nonhandicapped persons, should be constructed in the major metropolitan areas of Massachusetts, incorporating the following special features:

- Adherence to the United States of America Standards Institute's specifications.
- Location near education, training, employment and supportive services.
- Non restrictive eligibility requirements.
- Cafeteria, laundry and emergency attendant services.
- Parking under the building.

The Rehabilitation Council of the United Community Services of Metropolitan Boston and comparable agencies should undertake a complete investigation of available funding sources and review requirements influencing building and service administration procedures.

Transportation

MINIMUM TRANSPORTATION SPECIFICATIONS

97. Research on the transportation needs of severely handicapped persons in Massachusetts should be undertaken by private or university research organizations, in collaboration with the Massachusetts Bay Transportation Authority and other transportation companies.

98. Until official state or national specifications for the removal of public transportation barriers for the physically handicapped are developed, the following minimum specifications compiled by the Planning Commission should be used:

- Train and subway vehicle floors level flush and close to passenger platforms.
- Parking space for a wheelchair near vehicle drivers.
- Vehicle doors wide enough to admit a wheelchair and equipped with full height safety edges.
- Means of access usable by wheelchairs to the surface from the subway or elevated stations.
- Controls with proper safeguards to start, stop, or reverse elevators, moving ramps and escalators in collector's or starter's booths.
- Means of access usable by wheelchairs of boarding surface busses and street cars.

MASSACHUSETTS BAY TRANSPORTATION AUTHORITY

99. Directors of the Massachusetts Bay Transportation Authority should require new stations and new transit cars for the Authority's master expansion plan to be designed and constructed to be accessible to, and usable by, handicapped persons.

COMMUNICATING THE PROBLEM

Disabled persons can, and should, be integrated into the community with nondisabled persons. Many individuals with severe physical disability can function well in society if not blocked by architectural barriers which limit their full potential. Paradoxically, increasingly more funds are invested annually in the vocational rehabilitation of disabled men and women, yet little attention is paid to manmade barriers restricting their mobility.

Recent projections indicate that by 1980 half the American population may be permanently disabled, suffering from chronic disease, or over 65 years of age. Community facilities must be accessible to these people. The American Institute of Architects notes that in the next 40 years new construction in the United States will equal that of the nearly five centuries since Columbus discovered America.

Unless action is taken now, many of these new buildings and transportation systems will be constructed with architectural barriers such as:

- Doors too narrow for a person in a wheelchair.
- Stairs before entrances and exits.
- Rest rooms too small for a person in a wheelchair.
- Controls and equipment mounted out of reach.
- Subways which challenge the aged and infirm.

Testimony at public hearings conducted by the Vocational Rehabilitation Planning Commission indicated that these obstacles are a major reason why the disabled population of the Commonwealth is essentially a hidden population which cannot work, travel or participate in the affairs of everyday life.

No doubt a long list could be collected reflecting additional groups of individuals in key positions who remain unaware of the dimensions of the problem. If progress is to be made, public officials at all government levels, architects, builders, educators, medical and allied health professionals, community groups, and the communications media must be informed of the nature of this most serious problem. Even more importantly these individuals must take an active role in working to shape public attention and public policy toward the removal of architectural barriers.

Communicating the extent of the problem must be the first step. The National Commission on Architectural Barriers to Rehabilitation of the Handicapped concluded that the major obstacle to progress is lack of public awareness of the problem.[1] As a result of a nationwide survey of public attitudes towards the architectural barriers problem, this Commission reported that:

- 64% indicated they had given little or no thought to the problem of architectural barriers.
- 89% were not aware of any efforts to eliminate barriers in their communities.
- 63% thought that more should be done in the community to overcome obstacles to the handicapped.

Even among professional architects, the level of awareness of architectural barriers is low. A survey of 2,875 architects in the United States (about 10% of the total) by the National Commission on Architectural Barriers revealed that 65% were not familiar with the United States of America Standards Institute's *Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped*. These figures may be more readily understood with the finding that no school of architecture in the United States gives special or continuing attention to the problem of accessibility.

TOWARD IMPROVED BUILDING DESIGN

INCORPORATING MINIMUM SPECIFICATIONS

Although architectural barriers take countless shapes and forms, existing standard specifications, resulting in marked improvement in accessibility, could be incorporated at little additional cost in the design and construction of buildings generally open to the public. Particularly, the *Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped* issued by the United States of America Standards Institute (hereafter called the USASI Standards) offer the minimal features required to remove the major barriers that prevent many persons from using buildings and facilities. The National Commission on Architectural Barriers and the General Services Administration of the United States Government estimate that these specifications could be incorporated in the design of new buildings and facilities for about 0.5% of total construction costs. Ideally, these specifications should be incorporated in the design of all appropriate buildings used for housing, employment, education, and recreation. At a minimum, they should be required in the design of buildings that are planned for the use of the general public.

However, the incorporation of minimum standard specifications in new buildings will only solve part of the problem. Countless buildings already in use present obstacles to disabled persons. Provision must also be made to bring these structures up to a minimum level of accessibility. Existing buildings used by the public should be renovated to meet minimum principal specifications drawn from the USASI standards:

- One primary entrance should be usable (ground level or ramped) by individuals in wheelchairs and should be on the level making elevators accessible.

[1] See *Design for All Americans*, A Report of the National Commission on Architectural Barriers to Rehabilitation of the Handicapped (Washington, D.C.: Government Printing Office, 1968.)

- Elevators from the entrance level should provide access to all floors.
- Floors on a given story should have a nonslip surface and should be of a common level throughout or connected by a ramp.
- All doors and corridors should be wide enough to permit a wheelchair to pass comfortably.
- Bathrooms should be large enough to maneuver a wheelchair next to all facilities. A minimum of one toilet booth in each public rest room should be adapted for a wheelchair.

Cost of renovating will vary considerably depending on a design of existing buildings. In some instances it will not be feasible at all due to the design. The General Services Administration adopted the policy of requiring provision of minimum architectural barriers specifications whenever an existing building is renovated. If a similar policy were to be applied to existing buildings open to the public in Massachusetts the cost involved would be about 1% of the cost of the renovation. Costs considerably above that level would probably indicate that the desired changes were not architecturally feasible at all.

LEADERSHIP FOR REMOVING BARRIERS

Recognition of the architectural barriers problem by the public, and the incorporation of minimum standards into buildings, will only occur if effective leadership can be mobilized throughout the United States. The National Commission on Architectural Barriers recommended that every state enact legislation to establish the standards issued by the United States of America Standards Institute as the basic standards for barrier free facilities. Strong enforcement provisions and the establishment and financing of a unit to enforce the law were also recommended by the National Commission.

In Massachusetts, a mandate for the prevention and removal of architectural barriers in public buildings was expressed by the passage of Chapter 724, Acts of 1967 — "An Act Facilitating the Use of Public Buildings by Physically Handicapped Persons and Establishing a Board to Adopt Rules and Regulations for the Construction and Maintenance of Such Buildings."

This legislation established a seven man architectural barriers board, appointed by the Governor and located in the state Department of Public Safety. The board is empowered to make rules and regulations for the prevention of architectural barriers in buildings generally open to the public which are constructed, reconstructed, altered, or remodeled by the Commonwealth or any political subdivision.

In addition, the board should assume leadership in directing the efforts of relevant public agencies, professional associations, and building trades groups towards the goal of eliminating architectural barriers from all buildings generally open to the public. If compliance is impractical in a particular case, the board has the power to modify or waive rules or regulations upon request. Additionally, the board has the authority to secure compliance through enforcement proceedings in the superior court.

While the passage of this legislation is a sound first step, to achieve the maximum potential effectiveness of the board, the following recommendations should be implemented:

- Future members of the architectural barriers board should be appointed by the Governor from a list of knowledgeable people submitted by citizen groups having substantial concern, knowledge, and experience in the elimination of architectural barriers for the physically handicapped. Board members, including the three specified handicapped Board members, should be representatives from the fields of architecture, law, finance, construction, engineering, rehabilitation and safety.
- The architectural barriers board should promulgate rules and regulations which are consistent with the specifications of the United States of America Standards Institute — the uniform standard recommended for all the states by the National Commission on Architectural Barriers to Rehabilitation of the Handicapped.
- Legislation establishing the permanent full time position of executive secretary to the architectural barriers board should be enacted. Qualifications for this position should include experience in state government, construction, and architecture.
- The Department of Public Safety should continue and expand its cooperation in the enforcement of the rules and regulations of the architectural barriers board. The Board of Standards and inspectors of buildings should assist in the enforcement of architectural barriers standards.
- To insure the cooperation of architects and contractors, requests for waivers from the rules and regulations of the architectural barriers board should be acted on quickly within a specified time limit.

These recommendations are vital to the adequate functioning of the board as it was originally envisioned. At present, the board has only the part time services of an executive secretary. The initial months of the board's operations have made it clear that full time staff assistance is necessary if the board is to carry out its legislative mandate. Secretarial, clerical and technical staff to assist the executive secretary in the work of the board should also be provided.

LEGISLATION TO EXTEND BOARD JURISDICTION

A large number of buildings used by the public but financed from private or federal resources are vital to the everyday activities of disabled persons throughout the state. These include buildings used for education, training, employment, shopping, recreation, worship, and even to provide medical care. These buildings are not subject to the

regulatory procedures now applicable to public buildings under Chapter 724, Acts of 1967. Legislation should be enacted to extend the jurisdiction of the board to include all buildings generally open to public use, regardless of the sources of financing.

Increasing the jurisdiction of the architectural barriers board will provide the leadership and enforcement mechanism necessary for the implementation of minimum standards of accessibility in all buildings open to the public. This extended jurisdiction plus the addition of an adequate staff will raise the stature of the architectural barriers board and establish the board as the strong state agency that the National Commission on Architectural Barriers recommended. The board should assume a leadership role in directing the efforts of relevant public agencies, universities, professional groups, voluntary agencies, and other organizations concerned with the problem of architectural barriers.

INCORPORATION WITHIN UNIFORM BUILDING CODE

One method of establishing minimum standards of accessibility in buildings open to public use that has not received much attention is incorporation within local building codes. Building codes are locally enacted ordinances, usually based on national or state model or uniform codes, that set minimum safety standards for all buildings. Minimum standards, such as those formulated by the United States of America Standards Institute should be incorporated in appropriate sections of the national model building codes and uniform state codes which are the basis of most local codes.

In Massachusetts the process of building code reform began with a special legislative commission established in 1965 to study the problem of a uniform state building code. Presently being prepared, the legislative commission's report will reflect views expressed at public hearings and in survey questionnaires of local officials, urging legislative action establishing a uniform building code for the Commonwealth.

A recent legislative development related to development of a uniform building code is included in the law which established a state Department of Community Affairs This legislation included a section requiring the department to submit to the Governor and the legislature a model building code "complete in every regard" which takes "advantage of recommendations available from federal agencies and other national organizations." This mandate is further evidence of the likelihood of legislative reform of building codes. Therefore, the need to see that future codes recognize the problem of architectural barriers is evident.

EDUCATION AND TRAINING FACILITIES

ACCESSIBILITY TO ALL SCHOOLS

Physically disabled young adults want and need the opportunity to obtain the maximum education and training. Adaptability and knowledge are necessary for employment in an increasingly changeable and complex technical society. To meet the real and varied needs of all disabled young people a wide variety of educational and training opportunities should be available in both private and public schools.

Traditionally, severely disabled persons received education in special schools for selected diagnostic groups. Special schools are often needed for protection and for initial training in specific skills to enable disabled individuals to function more effectively in society. Home and hospital instruction and special classes provided by public schools represent other methods of providing education to severely disabled individuals. While these methods are effective, they do not provide enough opportunity for many capable individuals.

Recent experience demonstrated the effectiveness of combining early personalized hospital and home instruction with integration of the injured student into regular classes when medically feasible. Pioneer work in developing these ideas took place at Boston University and the University of Illinois after World War II. This approach provides optimum opportunities for emotional, social and intellectual growth at the least cost. However, Massachusetts has not implemented the combined early start and integration concepts on an ongoing basis. One reason for this deficiency is the existence of architectural barriers in so many of the older educational and training facilities.

A 1965 survey by the Massachusetts Association of Paraplegics of 126 primary and secondary schools in Massachusetts found that only 26 were accessible to disabled individuals. In 1965-1966, nearly 3,000 public school children in Massachusetts received home or hospital instruction because of temporary and permanent disabilities. Many of these students could have attended school were it not for insurmountable architectural barriers.

At higher educational levels the problem is even more serious. The same survey revealed that only two private universities in Massachusetts, Boston University and the Massachusetts Institute of Technology could be considered fully accessible to disabled persons. None of the low tuition state colleges is fully accessible.

Public and private education and training facilities in Massachusetts should construct all their new buildings and adapt their old buildings to accomodate physically disabled students in wheelchairs. New buildings should be adapted completely, using the guidelines provided in the United States of America Standards Institute's specifications. By 1976, old buildings should be renovated to include at least the adaptations already listed as minimum building specifications. These recommendations should apply to facilities such as primary and secondary schools, trade schools, two year community colleges, and four year colleges and universities. On campus transportation, usable by the physically

handicapped, should be provided where buildings are scattered over large areas or on hilly land

A UNIVERSITY PROGRAM FOR SEVERELY DISABLED STUDENTS

At least one university in Massachusetts should provide on campus supportive services for the severely physically disabled young adult so that he can obtain the training leading to the best opportunity for ultimate employment. The new University of Massachusetts at Boston, seems to present an excellent opportunity to accomplish this objective for the following reasons:

- Tuition would be lower than in private universities.
- All buildings can be constructed to accomodate students in wheelchairs.
- A full undergraduate curriculum will be offered.
- Location in Boston provides convenient access to many important community supportive services.

The University of Massachusetts at Boston should plan a barrier free campus and should provide direct and supportive services for severely disabled students. An office for handicapped students should be established to develop home and hospital educational programs, to provide and coordinate services for disabled students both on and off campus, and to participate in the planning of barrier free facilities. This office should be staffed by a professional director, an assistant director, and clerical staff, equipped with specialized teaching materials, with an annual budget of about $50,000.

BARRIER FREE HOUSING

PUBLIC HOUSING FOR DISABLED PERSONS

Many physically disabled persons are quite capable of living independently, but cannot find low rent, barrier free housing, with necessary supportive services. Consequently, disabled persons are forced into isolation in nursing homes, institutions, or private homes. They cannot travel without considerable assistance and inconvenience to their families and friends. This situation is especially difficult for young adults. Testimony at the public hearings sponsored by the Vocational Rehabilitation Planning Commission documented the wide scope of this problem.

Today, a large number of multiunit, low rent dwellings are being constructed throughout the state with the aid of public funds. Legislation already enacted in Massachusetts (Chapter 724, Acts of 1967) and at the federal level (P.L. 90-480) prohibits the construction of buildings with public funds that are inaccessible to handicapped persons. This legislation should be enforced to require that the design of all public housing and housing for the elderly be free from architectural barriers.

SPECIALIZED HOUSING FOR THE SEVERELY DISABLED

Strong efforts have been made by the physically disabled and by interested individuals and groups to construct special housing for disabled persons which would provide supportive services in a home like atmosphere. Although this movement has been beset by financial difficulties, the recent availibility of federal funds for specialized housing is sparking considerable new activity. High rise, low rent, barrier free dwellings with selective supportive features are being constructed in Seattle, Toledo, New York City, and most recently, in Fall River, Massachusetts.

Specialized housing appears to have one flaw in that a new type of ghetto might ultimately evolve, isolating the aged and the disabled from the main stream of community life. To check this trend and to assure full building occupancy, a flexible policy of integration with nondisabled persons should be maintained in any housing especially adapted to the needs of physically disabled persons. Housing should also incorporate these essential features:

- Design adhering to the United States of America Standards Institute's specifications.
- Location near education, training, employment and appropriate community supportive services.
- Both permanent apartments as well as temporary apartments and/or rooms should be available.
- A cafeteria should be located within the building with arrangements to deliver some meals to individuals as needed.
- Parking space should be available under the building to avoid the problems of outside parking in inclement weather.
- Automatic laundry facilities should be available in the building.
- There should be 24 hour attendant service coverage for the building. Many individuals can function quite independently, if they can have some assistance for dressing and bathing.
- An emergency call system should connect the building superintendent and the attendant's apartment to each tenant's bedroom and bathroom.
- Rent should be relatively low or subsidized by the state.
- Eligibility requirements should be flexible to permit the building to include elderly, nonhandicapped and handicapped residents to assure a normal community climate and also full occupancy.
- The building should be under the management of a permanent private or state agency which has a special interest in disabled individuals.

At least one building with these essential features should

be built in each of the Commonwealth's major metropolitan areas. The Rehabilitation Council of the United Community Services of Metropolitan Boston and comparable agencies should undertake a complete investigation of available funding sources and review requirements influencing building and service administration procedures.

TRANSPORTATION

TRANSPORTATION BARRIERS

Transportation has always been a serious problem for the physically disabled individual. Surveys of the known disabled population and rehabilitation professionals, as well as testimony at the statewide public hearings sponsored by the Vocational Rehabilitation Planning Commission, emphasized the following transportation problems that exist for the disabled and the aged:

- In urban areas, public transportation (MBTA, bus, trains) is available and is relatively economical. However, almost without exception, the transportation is totally inaccessible to disabled persons.
- In the rural areas, public transportation tends to be limited for everyone. The little that is available is inaccessible.
- Private transportation (taxi, ambulance, adapted small van vehicles, and personal automobile) is highly desirable but is too expensive.
- Many disabled people cannot utilize rehabilitation services or take advantage of educational and employment opportunities because transportation is either not available or not usable by them.

It has been estimated that 10% of the potential users of public transportation systems have permanent physical disabilities. Many other individuals also experience difficulty using public transportation. Public transportation usable by physically handicapped persons and aged individuals is second in importance only to accessible buildings and employment. Since the majority of those groups are in the low income bracket, they are more dependent upon public transportation than the average citizen.

Most of the cities and towns in Massachusetts are provided with bus services to a greater or lesser extent by local, private, bus companies. The Massachusetts Bay Transportation Authority (MBTA) provides rapid transit and bus transportation for the metropolitan Boston area. Although intensive efforts have begun at the federal level to stimulate studies and new mass transit facilities, nothing has yet been accomplished in Massachusetts to provide the inexpensive, accessible transportation needed by the disabled.

Satisfying the transportation needs of disabled persons by minimizing architectural barriers in public transportation facilities is an extremely complex problem. The architectural barriers do not exist in a single unit or building, but rather in an interwoven network of buildings and equipment. The solution is not quite the same as reducing the barriers in a public building so that disabled persons can gain easy entrance. No one visits a transit station or bus depot for the purpose of utilizing only that structure. Commuters enter one transit facility, use any number of transportation vehicles, and disembark at any number of stops or stations. Accessibility of only the input transit station would be of little value to the handicapped person as this would not result in travel freedom.

In many instances, the solution to the problem is obvious, such as having an operating policy established for transit employees to aid the blind. But for the greatest number of disabled persons, the solution is not so apparent. Existence of one obstacle in a travel plan may cause the disabled person to cancel the trip or to change from public transportation to a more expensive mode.

TRANSPORTATION RESEARCH

If physically handicapped persons and aged individuals are to have freedom of travel, a responsible program to meet the requirements of the disabled while not placing an inequitable and costly burden upon the public transportation companies will have to be developed. To resolve this problem an intensive research program should be conducted. Research will provide the necessary information and recommendations for all encompassing long range program for the reduction of architectural barriers in Massachusetts transportation facilities, both of the operational type as well as those relating to construction standards.

Elements in a transportation research program should include:

- Classifying the physically handicapped according to problems of mobility.
- Detailing the transportation needs of the disabled.
- Determining the various barriers involved in travel such as stairs, turnstiles, escalators, streetcars and buses.
- Relating the various barriers to travel needs and inconvenience of the various disability classifications so that cost benefit determinations can be made.
- Specifying procedures for establishing and enforcing standards for the construction and alteration of transportation facilities.

In addition to studying existing mass transportation systems, various other means of transportation should also be investigated to determine how they can be used to meet the needs of disabled persons. A variety of imaginative equipment for individual use has been developed, such as adapted automobiles, adapted small van type buses, motorized wheelchairs and carts, as well as regular taxi cabs. Many of these methods are satisfactory although they are always expensive and sometimes clumsy.

Table I

SPECIFICATIONS FOR MASS TRANSPORTATION FACILITIES[1]

Aerial and Subterranean Stations

- Off street parking at street level and adjacent to stations.
- Entrances to stations at ground level or ramped.
- Gates near regular turnstiles at least 30 inches wide and opened from the ticket booth.
- Floors within stations level or ramped.
- Elevators with controls mounted within reach of wheelchair users, available at every level and marked for use by those unable to use an escalator, moving ramp, spiral ramp, or stairs.
- If elevator expense proves prohibitive in initial construction of new stations, the elevator shafts built so as to permit elevator installation at a later date.
- Moving ramps or escalators (where elevators are not installed) equipped with manual controls permitting the station attendant to start, stop and reverse them. A railing extending at least three feet beyond the top and bottom of the moving ramp or escalator.
- Public toilets with at least one stall three feet wide and five feet deep with a 30 inch door which swings out. Hand rails mounted on either side of a wall mounted toilet with seat 20 inches from floor.
- An audio announcing system to aid the blind.

Rapid Transit Cars

- Doors at least 30 inches wide and equipped with full height safety edges to prevent closing on a person, crutch or wheelchair.
- Intervals at stops long enough to allow people of less than average ability to enter or leave the car in safety.
- Car floors level with passenger platforms.
- Car aisles at least 30 inches wide and clear.
- Space inside front door near driver for parking wheelchairs.

Buses and Street Cars

- Buses and street cars with boarding methods other than current steep steps. Two suggested methods are:
  - Construct covered, ramped platforms at appropriate vehicle stops level with floor vehicle, or
  - Install specially designed folding hydraulic plat forms to lift passengers to floor level. Such units are abailable for approximately $800.
- Door widths at least 30 inches wide and equipped with full height safety edges.
- Bus aisles at least 30 inches wide and clear.
- Space inside front door near driver for parking a wheelchair.

[1]These recommendations are based upon:

- United States of America Standards Institute's Specifications.
- Noakes, Edward H., Designing Public Transportation for Use by the Handicapped, *Performance*, October, 1966 (official publication of the President's Committee on Employment of the Handicapped).
- Specifications developed by Bay Area Rapid Transit Authority, San Francisco, California.

SPECIFICATIONS FOR PUBLIC TRANSPORTATION

At present, no architectural barriers specifications have been developed for mass transportation systems. Recommendations in Table I were developed from three studies that tried to set guidelines.

MASSACHUSETTS BAY TRANSPORTATION AUTHORITY (MBTA)

The MBTA serves a large metropolitan area around Boston consisting of about 79 cities and towns with a population of about 2.6 million. An estimated 10%, or 260,000 people, in this area experience difficulty in using public transportation.

Currently, the MBTA is developing a $700 million master transit plan. Consequently, this agency is one vital target at which to direct intensive efforts to make this public transportation system accessible to, and usable by, the physically disabled.

New stations and new transit cars for the MBTA's current construction program should be designed and constructed to be usable by all the public, including physically disabled persons.

The MBTA should follow the suggested specifications outlined in Table I in the transportation authority's expansion program now underway. All architects now under contract to the MBTA should be advised to use where applicable, the guidelines in Table I. These guidelines should be followed until more specific national specifications are developed or until final state specifications can be developed based upon a Massachusetts study of the transportation needs of the handicapped persons.

The Advertising Council

Rehabilitation for The Mentally and Physically Disabled Campaign

ONE-MINUTE RADIO SPOT #1

ANNOUNCER

Maybe you have a disability. Maybe you've accepted it. Maybe you're giving it the best years of your life. It doesn't have to be that way. Not today. Today you can get medical aid ... you can be taught to take care of yourself ... and you can learn to do a job you like. There's just one little catch. Before we can help you, we have to find you. Last year we managed to find and give hope to 200,000 people. But while we were doing that ... 300,000 more became disabled. And the gap gets wider and wider every year. So if you're disabled, or concerned about someone who is, do something about it. And do it soon. Write: HELP, Box 1200, Washington, D.C. H-E-L-P, Box 1200, Washington, D.C. 20013. You've got nothing to lose but your disability.

ADEQUATE HOUSING FOR DISABLED PERSONS

RECOMMENDATIONS

BASIC REQUIREMENTS

100 Adequate housing should be available for disabled persons in every service area. Such housing should emphasize the following:

- Intergration of disabled and nondisabled tenants whenever feasible.
- Freedom from architectural barriers.
- Provision of supportive services where needed to enhance independent living.

AREA PROGRAM FOR HOUSING THE DISABLED

101. An area housing program should be developed jointly by each area office of the Massachusetts Rehabilitation Commission and Mental Health Retardation Center to insure that adequate housing and related services are available for all disabled people.

POSITION OF AREA HOUSING COORDINATOR

102. A housing coordinator should be designated in every area office of the Massachusetts Rehabilitation Commission with experience in housing and community organization, to secure housing needed by clients, to stimulate the development of various public and nonprofit housing programs, and to develop various forms of housing and supportive services as needed by disabled persons living in the community.

HOUSING ADVISORY COMMITTEE

103. A housing advisory committee should be established by each area rehabilitation board to assist the area housing coordinator in surveying the need for housing and related services; in locating available housing, service personnel and foster homes; and in generally stimulating the expansion of housing resources.

POSITION OF STATE HOUSING SUPERVISOR

104. The new position of state housing supervisor should be established in the central office of the Massachusetts Rehabilitation Commission to provide guidance and information to area housing coordinators about available housing programs and resources for the disabled and to assist the area staff in their relations with public and private agencies interested in housing for the handicapped.

DEPARTMENT LIAISON

105. Every state department and agency dealing with problems of housing or with disabled persons should designate one qualified staff member in their central office to provide information to state and local housing coordinators and to facilitate the use of their agency's services by other agencies and by individuals.

ELIGIBILITY FOR PUBLIC HOUSING

106. Regulations of the Massachusetts Division of Housing, Department of Community Affairs, restricting the eligibility for low income public housing to families of two or more persons should be changed to permit occupancy by an unmarried handicapped individual.

USE OF PUBLIC HOUSING BY THE DISABLED

107. Massachusetts law governing eligibility for housing projects for the elderly should be amended to conform to the federal law to qualify all handicapped persons for such projects regardless of their age or family status.

108. Local public housing authorities should accomodate larger numbers of low income disabled persons in public housing by:

- Increasing the use of leased housing programs.
- Accommodating more disabled persons in housing for the elderly.
- Removing architectural barriers from units of public housing.
- Insuring that in new public housing where there is no elevator, apartments on the first floor are free from architectural barriers and where there is an elevator all apartments are free from architectural barriers.
- Establishing a clearer policy for deducting high medical and transportation-to-work cost before computing income for eligibility and rent purposes.

USE OF AVAILABLE FEDERAL AND STATE PROGRAMS

109. Planning, construction, or remodeling of housing for the disabled should be stimulated by state and area housing coordinators through appropriate federal and state programs.

Limited divided housing corporations, Model Cities programs and Federal Housing Authority mortgages could provide such assistance.

Area housing coordinators should assist handicapped persons in securing necessary resources and in obtaining consent of landlords as well as any required permits and licenses.

HOUSING TO SUPPORT TRAINING AND EMPLOYMENT

110. Group homes, hostels, dormitories and other forms of housing, which are free from architectural barriers and provide some supervision and assistance if needed, should be available for disabled persons who could not otherwise utilize training or sustain themselves in employment.

Public and private vocational rehabilitation agencies should investigate the potential use of such resources as a part of their service and of their followup procedure for clients placed in employment by them.

When appropriate, such housing should be a component of the specialized housing for the severely disabled recommended in the section on Architectural Barriers, and should be provided in close proximity to available services.

AN AREA PROGRAM TO IMPROVE HOUSING RESOURCES FOR THE DISABLED

A lack of suitable housing is a major problem for many handicapped persons. Testimony at the public hearings of the Planning Commission stressed that many handicapped persons lived in housing unsuited to their needs. Suitably located housing without architectural barriers would enable many handicapped persons to do for themselves what others must now do for them.

BASIC REQUIREMENTS

Housing needed by handicapped persons to maintain themselves independently varies greatly from one individual to the next. Some handicapped persons may only need a ramp and doorway wide enough to maneuver their wheelchair. Persons with more serious physical handicaps need housing free of architectural barriers as well as certain supportive services such as help with dressing, marketing, transportation and certain domestic chores.

Persons with severe physical handicaps, including those recovering from major injuries and those who are severely retarded or emotionally disturbed, may need full time supervision and nursing services.

A 1966 survey of housing needs of their members, conducted by the Massachusetts Association for Paraplegics found that, 47% of the respondents said they needed housing which was free of architectural barriers, 42% said they needed some attendant or nursing care and 18% indicated a need for resident around-the-clock services.

DESIRABLE FEATURES IN ALL HOUSING FOR THE HANDICAPPED

Housing for handicapped persons should include provision for both long term and transient accommodation. Where appropriate the following supportive services should be included:

- System to call for help in emergencies
- Availibility of transportation, including convenient parking facilities, near or within the building
- Restaurant or other provisions for cooked meals within the building, or food which is brought in
- Recreational or social programs
- Convenient laundry facilities within the building

PROVISION OF SERVICES IN HOUSING FOR THE DISABLED

In general, it would seem cheaper and more feasible to provide, or at least finance, the services needed by the disabled separately from their housing. If the cost of services were included in the rent of a nonprofit facility, the rent would become too high to qualify for a subsidy under leased housing Nor would the Welfare Department be willing to pay such a rent. Different residents require varying services which many of them are entitled to receive free of charge.

The following chart outlines the services which would be brought into the housing for the disabled:

Chart I
SERVICES IN HOUSING FOR THE DISABLED

Service	*Agency or Persons Providing Services*	*Possible Funding Sources*
Minor Nursing Services	• Visiting Nurses' Association • Home Health Aides	• Medicaid
Attendant Care	• Students • Supportive Personnel from Local Poverty Programs	• U.S. Department of Health Education and Welfare — Bureau of Higher Education • Local Anti-Poverty Programs
Homemaker Services	• Commonwealth Service Corps • Family Members	• Economic Opportunity Act Title V • Proposed Changes in Workmen's Compensation Act
Emergency Help	• Local Police and Fire Departments • Resident Janitor	• Municipal Funding • State Funds for Services to Handicapped Persons (as proposed)
Recreational and Social Programs	• Local Churches • Settlement Houses and "Y's" • Commonwealth Services Corps • Self Help Groups	• Private Funding • United Fund • Economic Opportunity Act

AREA PROGRAM FOR HOUSING THE DISABLED

Mental health-retardation centers and area offices of the Massachusetts Rehabilitation Commission should assume the responsibility of helping handicapped clients to find suitable housing and to secure needed supportive services as part of their commitment to provide referral and followup to appropriate community resources Local agencies should be stimulated to provide or to expand housing resources where they are inadequate.

Housing needs of mentally and physically disabled persons may vary considerably particularly with respect to the need for barrier free buildings and the degree of supervision and assistance which may be required. Despite certain unique requirements in construction and assistance which must receive proper consideration, the Mental Health-Retardation Center and the area office of the Massachusetts Rehabilitation Commission should establish a joint housing program to improve housing resources for the handicapped in each area.

One staff member from each area office of the Massachusetts Rehabilitation Commission should be designated as area housing coordinator to organize and develop programs to provide housing and related services for the disabled. He should assume the following major responsibilities:

- To secure housing needed by clients in order to utilize rehabilitation services.
- To stimulate the development of various public and nonprofit housing programs, and
- To develop various forms of housing and supportive services as needed by disabled persons living in the community.

Area Housing Advisory Committee

An area housing advisory committee should be established by each area rehabilitation board to assist the area housing coordinator in surveying the need for housing and related services in locating available housing, service personnel and foster homes and in stimulating the expansion of housing resources.

Members of the advisory housing committee should include representatives from realtors, builders, the hotel trade, local housing authorities (or local selectmen, if there is no public housing in a town), communications media, banks,

local colleges, the local antipoverty program, social agencies and churches, and the handicapped themselves.

With staff help, the advisory committee should conduct:

- Conduct client surveys to determine the need for housing and related services.
- Identify existing barrier free or easily convertible housing in the area, including furnished rooms, hotels, motels, rest homes and nursing homes.

Position of State Housing Supervisor

Several federal and state agencies have resources available which could be utilized to provide housing and related services to the disabled such as federal mortgages for state authorized nursing homes. Persons concerned with housing for the handicapped do not always understand which housing programs are relevant to the needs of their clients, under what circumstances funds may be available and how to apply.

The position of statewide housing supervisor should be established in the central office of the Massachusetts Rehabilitation Commission to provide guidance and information to area housing coordinators about all available programs and resources and to assist the area staff in their relations with public and private agencies interested in housing for the handicapped.

Department Liaison

Each government department and agency which is concerned with problems of housing or with the disabled should designate a liaison person who can provide information to state and local housing coordinators and to facilitate the use of their agency's services by other agencies and by individuals. The complexity and variation of housing programs makes such staff specialization necessary.

Liaison persons might be useful in the following agencies:

- The Department of Community Affairs to provide information regarding the feasibility of utilizing public housing programs and working with local housing authorities on the various federal nonprofit housing programs for the handicapped and help in drawing up proposals for federal funding.
- Department of Public Health for information on rest homes, nursing homes and extended care facilities and for advice in developing special facilities for the handicapped. (Nursing homes would have to be authorized by the state Public Health Department before sponsors could apply for a Federal Housing Authority mortgage for them and would also have to be licensed by the Nursing Home Division before they could take clients for public agencies such as Welfare or the Massachusetts Rehabilitation Commission.)
- Department of Mental Health regarding availability of funds for halfway houses or supervised homes for retarded persons.
- Commonwealth Service Corps for volunteers to help start or develop ancillary services in connection with housing also for part time pay for handicapped volunteers to work on home finding services.

ELIGIBILITY FOR PUBLIC HOUSING

Since the majority of handicapped people appear to have limited income, most of them can only afford low rents and may require public housing. However, some housing authorities declare them ineligible and others give them very low priority. Federal housing for the elderly who are handicapped use the following guidelines:

> Sec. 202 of the Housing Act of 1959 (Title 12, Sec. 1701 a.) "A person shall be considered handicapped if such a person is determined . . . to have a physical impairment which (a) is expected to be of long, continued and indefinite duration, (b) substantially impedes his ability to live independently (c) is of such nature that such ability could be improved by more suitable housing conditions." Or, people who "are under a disability as defined in sec. 223 of the Social Security Act."

There is considerable latitude for local authorities to set their own priorities in admission policies. There also appears to be some variation in the interpretation of the law. For this reason, a responsible agency such as the State Department of Community Affairs should clarify the eligibility and priority laws as they affect the handicapped. A clear written statement should be disseminated to local housing authorities, to area housing staff, to housing advisory committees and to the handicapped. If the law does exclude any category of the low income disabled such as single middle aged persons, the law should be altered to make them eligible for public housing.

Regulations of the Massachusetts Division of Housing restricting eligibility for low income public housing to two or more persons should be changed to permit occupancy by an unmarried handicapped individual. Massachusetts law governing eligibility for housing projects for the elderly should be amended to conform to the federal law to qualify all handicapped persons, regardless of their age or family status. Such projects should conform to the standards discussed in the architectural barriers section of this report.

INCREASED USE OF PUBLIC HOUSING BY THE DISABLED

Public housing authorities in cooperation with the area housing coordinator should accomodate larger numbers of low income disabled persons in public housing in the following ways:

The Increased Use of Leased Housing Programs

In leased housing the federal government contracts with the local housing authority to provide a subsidy roughly equivalent to the federal subsidy which would be required, on an annual basis, for a number of units of newly constructed public housing. Instead of building new public housing the local housing authority looks for existing private or nonprofit moderate rental housing meeting specifications for safe, sanitary accommodations. These accommodations are usually rented for four years at the Commercial rent and are used for persons who are eligible for public housing. The tenant pays the low public housing rent and the local authority pays the difference to the landlord out of the federal subsidy.

Handicapped persons may get an apartment near to their work meeting individual requirements Such an apartment may be safer and more convenient than the rough environment of many public housing projects.

The subsidy is a block grant and is not required to be the same for each unit. Thus, in special cases, such as with barrier free housing for the handicapped, a higher subsidy may be paid. Housing especially constructed or modified for the handicapped could be leased by a housing authority. Small towns not now able to undertake the complicated task of building their own housing developments with a federal subsidy might be persuaded to undertake the much less complicated operation of a leased housing program. This possibility should be explored by the area housing coordinator and local housing advisory committee.

Massachusetts passed a leased housing bill but little use has been made of this program so far.

Accommodating More Disabled Persons in Housing for the Elderly

Housing for the elderly is built to different specifications than mixed occupancy housing and in some cases has less architectural barriers or might be easier for disabled persons to adapt. Usually a communal recreation room exists within the building and housing authorities are allowed to install communal kitchens if some other agency will provide meals on wheels or similar programs for the residents. Sometimes there are emergency call bells in the apartments and/or provisions for a resident janitor. At times social or recreational programs for the elderly are conducted in the building and might be adapted to serve the handicapped. Other residents are less likely to be a hazard to a disabled person than they would be in many of the large mixed occupancy developments.

Insuring That a Portion of New Public Housing Construction is Free From Architectural Barriers

Future public housing in Massachusetts should be built without architectural barriers. Where there no elevators first floor apartments should be free from architectural barriers; where there is an elevator, all apartments should be so constructed. Although normally there is a top per unit federal subsidy on general low income public housing, an extra allowance can be approved by the federal government for a special program Fall River obtained this allowance in order to include facilities for the handicapped.

Income Deductions for Medical and Transportation Expenses

A handicapped person's rent paying capacity is often seriously diminished by essential medical expenses or high costs of transportation due to his disability. This should be taken into account in computing his income for purposes of determining eligibility and rent. State housing bureau guidelines (1959) allow deductions for transportation expenses which exceed normal and usual amounts in determining net income for public housing eligibility and rentals.

Housing authorities contacted by Planning Commission staff indicated that they permit deductions for excessive medical expenses. However, there are no state regulations which formalize this requirement and various criteria are utilized.

A more explicit policy should be adopted for deducting high medical and transportation-to-work costs before computing income for eligibility and rent purposes.

ALTERATION OF HOUSING

There are no funds available within local housing authority budgets for making alterations to existing buildings to remove architectural barriers. However, there are no legal objections to a housing authority accepting funds from another agency for this purpose. At present the Massachusetts Rehabilitation Commission makes limited alterations in houses owned by clients but not those owned by private landlords. The Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Department of Public Welfare and private groups such as local churches should explore the feasibility of paying for the alteration of some public housing to remove existing architectural barriers and make such apartments permanently available to disabled clients.

Funds should also be made available to pay for the alteration of privately owned housing, so it may be used by handicapped persons. Area housing coordinators should assist handicapped persons in securing necessary resources and in obtaining consent of landlords as well as any required permits and licenses.

PROBLEMS IN PUBLIC HOUSING

Although public housing at present would provide the lowest available rent for sound housing and potentially is capable of producing a suitable type of housing unit, it

would be unrealistic to expect that it will solve all the housing problems of the handicapped. There are many obstacles.

There are waiting lists for most existing housing developments now, particularly for the elderly. Most towns have residence requirements which are sometimes very long. Many small towns do not have a public housing program and do not appear to have the wish or ability to develop one. At present there is no legal means whereby small towns could cooperate to produce a joint housing project or have a larger agency deal with the complicated bureaucratic procedures necessary to achieve this. In addition, small projects tend to have higher rents. Often small towns find it easier to build their public housing through the state program dealing with staff located in Boston, than through the federal program which requires that the town meet certain rather difficult requirements and has its nearest office in New York. However, the state subsidy is lower than the federal one and has no provision for rising costs of management. This has placed several state-aided housing projects in financial jeopardy.

The handicapped appear to have very low priority in the admission policies of many local housing authorities. Only Fall River is building public housing specially designed for the handicapped. For these reasons it seems necessary to consider additional housing alternatives for the handicapped.

USE OF AVAILABLE FEDERAL AND STATE PROGRAMS

State and area housing coordinators should utilize all appropriate federal and state programs which could provide assistance for the planning, construction or remodeling of housing for the disabled. Federal assistance to nonprofit or limited dividend housing corporations, Federal Housing Authority mortgages for the construction of nursing homes approved by the state Department of Public Health, and comprehensive programs planned under the auspices of Model Cities, provide varying possibilities for expanding the housing resources for the disabled.

If the area housing coordinator and his advisory committee decide that existing housing resources cannot be stretched to meet the needs of the disabled, they should explore the possibilities for developing nonprofit and limited dividend housing corporations which can receive financial assistance from the federal government. In the past, this assistance has not been adequate to produce low rent housing. As a result, nonprofit and limited dividend housing in the United States have so far been moderate rather than low rental. However, local housing authorities can use units of this type of housing for their leased housing programs thus bringing the rent down to public housing levels for eligible clients. Public housing authorities are also permitted to lease units in advance in nonprofit housing which is about to be constructed thereby assisting a nonprofit housing project in its early stages.

Model Cities

Model Cities programs which are in existence in six cities in Massachusetts encourage cooperative efforts between public and private agencies to produce new administrative combinations for joint programs, and stress the building of low rent housing. Funds are available for planning such programs, and federal agencies have pledged their cooperation. There are plans to provide federal grants to implement these programs beyond the planning stage. This indicates a possibility of demonstration programs in Model Cities which might produce housing for the handicapped under mixed auspices. Combined auspices might have additional advantages for the handicapped since it would allow for a variety of residents under one roof. In this way, a hospital cooperating with the Massachusetts Rehabilitation Commission and a local housing authority might be able to house transient and long term patients and staff in one building. A university might be able to house handicapped and nonhandicapped students in one dormitory and pay able-bodied students under the Work Study Program (United States Department of Health, Education and Welfare, Bureau of Higher Education) to provide supportive services to their handicapped fellow students.

HOUSING TO SUPPORT TRAINING AND EMPLOYMENT

Supervised living facilities including group homes, hostels and dormitories, should be available in each area for clients for area sheltered workshops and other disabled persons who need some supervision or assistance to utilize training or sustain themselves in employment. Housing should be accessible to training facilities and the mainstream of community activities.

Some disabled persons require supervision and certain services in addition to barrier free housing. The extent and type of help varies from intensive therapeutic care or intensive nursing care to minimally supervised residences providing some direct services.

This report focuses only on some potential models of supervised residences for persons in training, going to school, or in extended or competitive employment, both married and unmarried, whose physical or mental disability makes it necessary that they receive help with dressing or other routines or supervision in activities related to health and recreation, but who do not require intensive care or supervision.

The number of supervised housing units which would be needed is difficult to determine at this time. Data should be compiled from the area offices of the Massachusetts Rehabilitation Commission, area sheltered workshops, the community mental health-retardation centers and other agencies serving the disabled.

A supervised housing program could begin in each area with at least two supervised living facilities, each accommodating between 25-30 clients. These facilities should be cen-

trally located or should provide necessary transportation for residents.

Certain resident staff should be considered depending on the needs of the individuals in residence. Assistance in dressing, shopping, diet, social and recreational activities, helping to facilitate involvement in every day functions (transportation, budgeting, banking, making appointments, purchasing clothes), and getting to work should be included Additional supervision and nursing care should be provided to assist the more severely disabled mainly extended workshop clients.

To eliminate duplication of facilities, supervised living facilities should be utilized by a mixed clientele and include disabled persons in competitive employment and those who are transitional and extended workshop clients. Facilities should be free of architectural barriers and be adequately equipped.

Consideration should be given to placing a workshop directly in a housing unit accommodating a sufficient number of disabled persons.

A major emphasis in the living facilities should be the development of social group membership. The group can serve as a source of information on physical health and appearance, and may assist individuals in work related areas, improving work habits, job interview and application techniques and social relationships. Social skills developed in the living facilities should be transferable to the community, home and job. Group experiences can enable an individual to learn how to cope with his disability and increase his feelings of self worth. The group offers the resident an opportunity to become a necessary and functioning member of an intimate organization, and emphasizes every clients' individual abilities.

REHABILITATION OF THE HANDICAPPED CAMPAIGN
MAGAZINE AD NO. REH-7-69-4-9/16" x 5"

TRANSPORTATION FOR DISABLED PERSONS

RECOMMENDATIONS

TRANSPORTATION FOR EDUCATION, TREATMENT AND SOCIAL SERVICES

111. All direct service agencies providing education, treatment and social services such as sheltered workshops, public welfare agencies, hospitals, and mental health centers should provide or purchase transportation for those clients who because of their disability could not otherwise utilize their services.

TRANSPORTATION TO WORK

112. The Commonwealth should assume the responsibility for subsidizing the cost of transportation to and from work for those disabled persons who are capable of competitive employment, but for whom transportation costs, relative to wages, make work economically impractical.

Subsidies should include taxi fares and the leasing of specially equipped cars to disabled persons who can drive.

ELIGIBILITY FOR PROGRAM

113. Eligibility for transportation to work subsidies should be determined by the area office of the Massachusetts Rehabilitation Commission on the basis of a standard formula relating cost of transportation to wages earned.

The Commonwealth, through the Massachusetts Rehabilitation Commission, should provide funds for this program when they are not available through other sources.

To determine the scope and cost of the program, transportation subsidies should be started on an experimental basis in one geographic service area.

MONTHLY TRANSPORTATION ALLOTMENTS

114. A monthly transportation allotment should be provided by the Commonwealth to disabled adults unable to use public transportation to enable them to engage in normal activities such as shopping, visiting friends, attending community programs, or religious observances.

Funds for the program should be made available by the state through the Massachusetts Rehabilitation Commission. To determine the scope and cost of the program, transportation allotments should be started on an experimental basis in one geographic service area.

The eligibility of clients and the amount of this allotment should be determined by the area office of the Massachusetts Rehabilitation Commission on an individual client basis.

TRANSPORTATION COORDINATORS

115. A transportation coordinator should be designated in every area office of the Massachusetts Rehabilitation Commission to help determine client eligibility for transportation to work subsidies and for transportation allotments, to help agencies in the area to organize client transportation, and to work with school committees to secure transportation for physically handicapped children.

STATE TRANSPORTATION SUPERVISOR

116. A new position of state transportation supervisor should be established in the central office of the Massachusetts Rehabilitation Commission to assume overall responsibility for the agency's transportation program including guidelines for client eligibility, consultation to area transportation coordinators and the development of transportation resources for the disabled.

TRANSPORTATION TO SCHOOLS

117. The area transportation coordinator should work with local school committees to insure that physically handicapped children, including those in wheelchairs, receive necessary transportation to enable them to attend regular classes.

STUDY OF TRANSPORTATION REQUIREMENTS

118. The Massachusetts Rehabilitation Commission should compile existing studies on the transportation needs of disabled persons and conduct additional surveys where indicated, in collaboration with the Departments of Mental Health, Public Health, Public Welfare, appropriate universities and representatives from the disabled, to determine the transportation requirements of disabled persons in the Commonwealth as well as the available and potentially available transportation resources to meet these needs.

WHAT KIND OF TRANSPORTATION IS NEEDED?

Some disabled persons will not be able to avail themselves of comprehensive area rehabilitation services or of employment opportunities because they are not mobile. Unless services are so decentralized that they are provided within homes or in immediate neighborhoods, these handicapped persons will be neglected unless suitable transportation is made available to them. Decentralization of services to such an extent is usually not feasible because of the expense, the difficulty of staffing large numbers of services within an area, or the possibility of finding a sufficient number of clients to justify the service on a very small scale.

Three levels of transportation are needed by disabled persons who cannot use public transportation, namely:

- To receive education, treatment and social services.
- To get to and from work.
- For social, religious and similar activities.

All three levels of transportation are of importance to disabled persons. However the first two, should receive primary consideration as a public responsibility and as a mechanism to support comprehensive services in each area.

TRANSPORTATION FOR EDUCATION, TREATMENT AND SOCIAL SERVICES

Each program serving disabled persons should assume responsibility for transporting clients who require such help in order to utilize the service. For the most part a taxi type of arrangement involving door-to-door pickup would be required. Small buses, in some cases specially designed to accommodate persons in wheelchairs, should be utilized. Administrative details of client transportation can best be worked out by individual agencies which either own vehicles or by contract for such services.

Costs for transportation for private agencies should be included as part of the client fees. Authorization for transporting clients of private agencies must be secured from the department paying the client's fee. Where state departments are providing services directly to clients, transportation costs should be assumed as part of the total cost of serving the client.

TRANSPORTATION TO WORK

Many disabled persons could hold competitive jobs but cannot use public transportation to get to work. Where taxis or other forms of expensive transportation must be utilized almost half of some worker's pay could be spent for transportation alone, making work economically impractical.

A job in competitive employment not only provides a basic income for a disabled person but is a source of self respect which should be fostered.

The Commonwealth should subsidize the cost of transportation to and from work for disabled persons whose transportation costs, relative to wages make work economically impractical.

A disabled worker earning the federal minimum wage of $1.60 per hour, who spends $5 a day for taxi fare to and from work should receive a $4.50 daily subsidy (less cost of public transportation). If this same worker made $150 per week, he should not receive any subsidy.

ELIGIBILITY FOR PROGRAM

A formula relating cost of transportation to wages earned should be developed by the state transportation supervisor of the Massachusetts Rehabilitation Commission. Eligibility and amount of the subsidy should be determined on an individual basis by the area transportation coordinator of the Massachusetts Rehabilitation Commission on the basis of this formula.

In some cases the leasing of specially equipped cars may provide the best transportation solution and this possibility should be explored by the transportation coordinator.

It is not possible to give an accurate estimate of how many persons would require transportation to work subsidies.

Transportation subsidies could cost on the average of seven to eight hundred dollars annually per person. Therefore, the transportation subsidy program should be started on an experimental basis in one geographic service area to determine the scope and cost of the program and to evaluate client eligibility and the most economical way of providing the service.

MONTHLY TRANSPORTATION ALLOTMENTS

Disabled persons who cannot use public transportation can hardly ever participate in normal activities such as shopping, visiting friends and attending community programs or religious observances, unless someone takes them or they can afford a taxi.

The Commonwealth should give monthly transportation allotments to disabled adults who are unable to use public transportation.

Eligibility for the program should be determined on an individual client basis by the area transportation coordinator of the Massachusetts Rehabilitation Commission on the basis of an interdisciplinary team evaluation.

About five dollars per week would be required per person to enable them to carry out even a few activities in the community. It is not possible to draw comparisons from similar programs to help estimate the extent and scope of transportation allotments in Massachusetts. Therefore, the program should be started on an experimental basis in one geographic service area.

The area transportation coordinator should explore the possibility of using a small bus owned by the area office of the Massachusetts Rehabilitation Commission to transport

and provide some of the transportation needed by disabled persons in the area.

TRANSPORTATION COORDINATORS

At this time, it does not appear feasible to develop an integrated transportation system in each area providing transportation for disabled persons to get to work, to training, to education and to attend to daily life activities. Although there will be some fragmentation in providing these services, the area office of the Massachusetts Rehabilitation Commission will have a major responsibility in the program including disbursement of transportation funds to agencies and individual client eligibility, uncovering transportation resources and coordinating the program. These widely ranging responsibilities and the large amounts of money involved necessitate the designation of a transportation coordinator in each area office of the Massachusetts Rehabilitation Commission to assume responsibility for the program.

STATE TRANSPORTATION SUPERVISOR

The position of state transportation supervisor should be established in the central office of the Massachusetts Rehabilitation Commission.

Duties of this position should include developing guidelines for client eligibility and for fees charged by agencies for transporting clients who are the responsibility of the Commission. The state transportation supervisor should have overall responsibility for the transportation program of the Massachusetts Rehabilitation Commission. He should provide consultation to area transportation coordinators and should coordinate his work with other public agencies providing transportation for their clients.

TRANSPORTATION TO SCHOOLS

Some physically disabled children, particularly those in wheelchairs, are unable to attend public school because they cannot be transported by the school department vehicles.

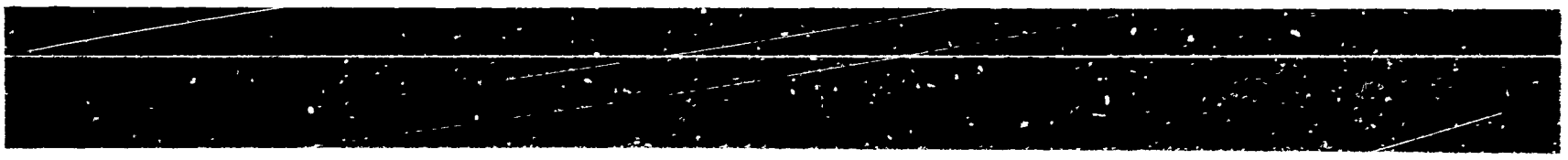
Special taxi service may have to be instituted to provide transportation for some disabled children in the area.

The area transportation coordinator should work with local school committees to insure that such transportation is provided.

TRANSPORTATION STUDY

Evidence regarding the needs for large scale transportation for disabled persons is not clear in any one direction. A 1968 study by Arthur D. Little, Inc., Cambridge, Massachusetts, found that mobility is not a major impediment to the employment of disabled persons. On the other hand, testimony at public hearings and the results of a 1966 survey conducted by the Massachusetts Association of Paraplegics of agencies serving the disabled, indicates that transportation is of vital importance to many disabled persons and is not sufficiently available.

The Massachusetts Rehabilitation Commission should gather existing studies on the transportation needs of disabled persons and conduct additional surveys where indicated, in collaboration with the Departments of Mental Health, Public Health, Public Welfare, appropriate universities and representatives from the disabled to determine the transportation requirements of disabled persons in the Commonwealth as well as the available and potentially available transportation resources to meet these needs.



REHABILITATING THE PUBLIC OFFENDER

RECOMMENDATIONS

DIAGNOSIS AND EVALUATION

119. All public offenders should receive a comprehensive medical, psychological, social and vocational diagnosis and evaluation as early as possible before permanent assignment to an institution and program of rehabilitation.

120. Court clinics should utilize rehabilitation counselors according to plans developed by the Massachusetts Rehabilitation Commission, the Commissioner of Probation, and the Division of Legal Medicine of the Department of Mental Health.

121. Youth Service Board detention-reception centers and adult correctional institutions should utilize rehabilitation counselors during the intake screening and classification process.

122. Judges should be empowered to refer convicted adult offenders to diagnostic programs before sentencing.

PREVOCATIONAL SERVICES

123. All public offenders should receive comprehensive prevocational rehabilitation services as needed including personal adjustment training, development of social skills, remedial and adult education and training in tasks of daily living.

RESTORATION SERVICES

124. All public offenders should receive physical and mental restoration services as needed using community resources when necessary. Attention should be given to all physical defects which constitute a barrier to employment and personal adjustment.

VOCATIONAL TRAINING

125. Prison industries should be revised and integrated with institutional vocational training programs geared to meet the needs of the inmates.

126. Chapter 127 of the General Laws relating to prison industries should be amended to permit contractual and subcontractual arrangements with private industries to purchase prison-made products.

127. Vocational training programs should be financed through a variety of sources including income earned in prison industries, federal-state vocational rehabilitation funds, state appropriations, and other available public or private funds. Consideration should be given to creating a nonprofit corporation to receive funds from various sources to be used exclusively for the expansion and improvement of vocational training programs.

RELEASE PROGRAMS

128. Work release programs staffed by qualified work release supervisors should be available to selected inmates in all state and county correctional institutions.

129. Release programs should be extended to permit qualified inmates to take advantage of education and training programs available in the community.

130. Inmates approaching discharge or parole should be permitted to leave the institution under proper supervision to meet with employers or to participate in job interviews.

COMMUNITY BASED PROGRAMS

131. Funds should be provided to purchase services from and place probationers and parolees in privately operated, approved rehabilitation residences.

132. The Parole Board, the Commissioner of Probation, and the Department of Correction should develop a rehabilitation residence designed to demonstrate the effectiveness of short term prerelease and postrelease residential programs and to provide research and training opportunities to enable staff to develop and operate additional rehabilitation residences where needed.

DISCHARGE AND PLACEMENT

133. Formal cooperative agreements for the job placement of all public offenders should be developed between the Massachusetts Rehabilitation Commission, the Division of Employment Security, Parole Board, the Commissioner of Probation and the Department of Correction.

134. Inmates of all county houses of correction should be encouraged to consult counselors provided by the Division of Employment Security prior to discharge or parole.

135. To provide youth with knowledge of occupational training and supportive services available in the community, prerelease and postrelease programs should be expanded by the Division of Youth Service in cooperation with the Massachusetts Rehabilitation Commission and the Division of Employment Security.

136. A Council of Cooperating Employers and Labor Unions should be established by the Governor's Advisory Committee on Correction in cooperation with all agencies serving adult and juvenile offenders to advise and assist in developing training and work release programs, to increase job placement opportunities, and to work towards identifying and removing obstacles to the employment of exoffenders and discharged deliquents

PUBLIC OFFENDER SERVICES WITHIN THE MASSACHUSETTS REHABILITATION COMMISSION

137. A position of Supervisor of Programs for Public Offenders should be established to develop, direct and coordinate all programs and services for the public offender within the Massachusetts Rehabilitation Commission.

138. The Massachusetts Rehabilitation Commission should initiate cooperative agreements with all correctional agencies to use correctional funds to match additional federal monies to expand vocational rehabilitation services to public offenders.

139. The Massachusetts Rehabilitation Commission should expand its programs to provide comprehensive rehabilitation services to all state and county correctional institutions.

INTERAGENCY APPROACHES

140. To plan and coordinate the rehabilitation efforts of all agencies working with public offenders and to work toward the development of integrated programs in the areas of research, professional manpower and public awareness, the Governor's Committee on Law Enforcement and Administration of Criminal Justice should establish a Subcommittee on Rehabilitation. The subcommittee should consist of representatives of public and private vocational rehabilitation agencies, the Division of Employment Security, and representatives of public and voluntary correctional agencies.

141. Public awareness, education, and information programs should be expanded by all agencies serving the public offender to convey to the public the facts concerning the value of a rehabilitation approach to crime prevention. The Governor's Committee on Law Enforcement and Administration of Criminal Justice should provide staff and financial assistance for these programs.

VALUES AND GOALS

In planning for the provision of vocational rehabilitation services to all handicapped persons, the public offender should not be overlooked. Each year more than 11,000 persons are imprisoned by Massachusetts courts. A high percentage of juvenile deliquents, probationers, parolees, and inmates of all of our state and county correctional institutions need, and are entitled to, vocational rehabilitation services.

Job placement is the major focus of vocational rehabilitation programs. Reduction of recidivism is the major focus of correction programs. However, both programs have identical long range goals. Vocational rehabilitation programs and corrections programs both aim to provide the individual with the opportunity to develop the abilities and skills necessary to participate in the community and to achieve personal dignity. Both programs also recognize the central value of employment to individual adjustment, the value of a fully productive citizenry, and the social and individual costs of dependency.

Some confusion exists in the public mind concerning the correctional goals of crime prevention and rehabilitation of the individual offender. Rehabilitation programs have been opposed on the grounds that the programs undercut the deterrent effect of criminal penalties and hamper efforts to prevent crime. However, there is no real conflict between crime prevention and rehabilitation, as noted in the follow-

ing principle stated by the President's Commission of Law Enforcement and Administration of Justice. "The ultimate goal of corrections . . . is to make the community safer by reducing the incidence of crime. Rehabilitation of offenders to prevent their return to crime is, in general, the most promising way to achieve this end."

Before effective vocational rehabilitation programs can be introduced into the correctional field, two conditions must be satisfied:

- Vocational rehabilitation services must be ready to enter the correctional field.
- The correctional field must be ready to accept and utilize vocational rehabilitation services.

In order to meet the first condition, vocational rehabilitation personnel should become thoroughly educated as to the structure, functions and limitations of probation, parole and correctional agencies. Constraints of an authoritarian setting should be recognized and the responsibility of probation, parole and correction officials for supervision and treatment of offenders should be respected. Vocational rehabilitation should be looked upon as an integral part of a comprehensive correctional program encompassing adequate medical and mental health services, education, religious and recreational programs, and appropriate discipline.

Fulfillment of the second prerequisite demands a positive commitment to a rehabilitation model for corrections — a program which views crime and delinquency as problems of individuals and deals with the public offender from sentencing to discharge, by individualizing the person and providing a broad range of services to meet his needs. Although the principle of rehabilitation has been widely accepted, it has not been translated into adequate programs for the offender. Except for periodic responses to crisis situations within the correctional system, the development and expansion of rehabilitation programs has not received sufficient public support. Increased emphasis on correctional rehabilitation, both in the community and in institutions, must accompany the development of vocational rehabilitation services for offenders.

EXISTING SERVICES

No state governmental function is more fragmented than the post conviction phase of criminal justice Responsibility for control and rehabilitation of convicted offenders is divided among six state agencies, the 14 counties and the city of Boston. Thirty-four state and county institutions house more than 7,500 convicted adult offenders and juvenile delinquents. An additional 46,000 are under the formal supervision of probation and parole officers. Specialized services to offenders in prisons and in the community are provided by the Departments of Mental Health and Public Health. Under the existing structure of correctional services, it would not be unusual for three different agencies to be involved in the rehabilitation of the same offender.

Generalizations about existing correctional services are difficult because of the multitude of agencies serving the public offender and the heterogeneity of the offender population. However, consideration of four groups of public offenders will be helpful in securing an answer to the problem:

- Adult offenders in the community
- Institutionalized adult offenders.
- Juvenile offenders in the community.
- Institutionalized juvenile offenders.

Adult Offenders in the Community

Eighty-seven percent of the adult offenders (17 years and older), under formal public supervision, are on probation or parole in the community. In addition, many more exprisoners, fully discharged from institutions, live in the community without supervisio... Nearly all of the offenders presently confined in our institutions will eventually reside in the community.

The magnitude of the problem is not reflected by the allocation of staff and resources to community programs. Three hundred thirty probation officers staff the district and superior courts of the Commonwealth. These officers, with average caseloads of 125 and in some cases up to 300, are also responsible to the court for presentence investigations and reports. Forty-two parole officers are charged with the responsibility of preparing inmates for parole as well as for supervision in the community.

Probation and parole personnel receive little support from the Commonwealth. With the exception of the eighteen courts having established court clinics providing mental health services, the probation officer is on his own in developing a rehabilitation program for the offender in the community. Parole officers face a similar situation. Mental health services at the Boston parole clinic, Drug Addiction Rehabilitation Board facilities, and two parole employment officers are the only specialized public services available to exprisoners. Lack of specialized services and poor coordination with existing generic services in the community impede the offender's rehabilitation. Private organizations such as the Massachusetts Correctional Association, the Salvation Army, the YMCA, and others provide services to aid the offender. However, their limited resources have not been able to meet the need.

Vocational rehabilitation for public offenders in the community is almost totally lacking. No formal relation exists between the Massachusetts Rehabilitation Commission and probation and parole officers for serving adult offenders. As far as can be ascertained, only a handful of offenders have received any vocational rehabilitation services. While services have been made available to a few offenders, it is evident that many more probationers and parolees could benefit from vocational rehabilitation. A recent survey of probation officers conducted by the Commissioner of Probation in cooperation with the Planning Commission, indicates that more than 2,000 adults currently on probation are in some way physically disabled. Throughout 1966, 2,400 mentally disordered probationers were seen in court clinics.

Need for vocational rehabilitation services must be determined on an individual basis. All offenders designated as physically or mentally disabled would not require a full

range of services. However, even a minor physical disability can be a substantial handicap to employment when associated with demonstrated behavioral deviations, inadequate education, and the poor employment background characteristic of the offender. In addition to those factors which combine to render the adult probationer a handicapped individual, the parolee faces obstacles resulting from his removal from the community. Institutionalization deprives him of normal job experiences, social relationships and opportunities for education and training. Upon release, the offender must also contend with negative public reaction to his criminal record and exconvict status.

Institutionalized Adult Offenders

Institutionalized adult offenders are found in county houses of correction or state correctional institutions.

COUNTY INSTITUTIONS. Each county, except Dukes and Nantucket, operates a house of correction. Although the Commissioner of Correction has legal authority to supervise the county institutions, they are actually autonomous and under the control of the county sheriff, except in Suffolk County, where the Penal Commissioner of Boston has control.

Approximately 9,000 persons are sentenced to county institutions during the year with an average daily population of about 2,000. Institution populations range in size from about 20 at Greenfield House of Correction to more than 350 at Deer Island House of Correction. Most of the inmates serve short sentences; during 1964, 85% were sentenced to less than six months.

Complete data on the characteristics of inmates in our county institutions are not available. However, a recent survey of the houses of correction in Barnstable, Bristol, Norfolk, Suffolk and Worcester Counties indicates that the inmate population is young (50% under 25; 80% under 35) and lacking in education (more than 80% school dropouts). Many inmates are first offenders who will graduate to state correctional institutions if they are discharged without adequate preparation for life in the community.

Very few meaningful rehabilitation programs exist in our county houses of correction. Most of the county facilities are outmoded; all but two were built in the last century. In general, personnel are untrained in correctional treatment. Most work programs exist for the maintenance of the institution rather than for the vocational training of the inmates. Laundry, kitchen, farming, carpentry, painting, and other institutional tasks keep prisoners busy, but are of little value in terms of training the offender for a job in the community.

Some excellent rehabilitation programs, such as the work release program in Norfolk County and the educational programs in Worcester County, have been initiated. However, most rehabilitation efforts have been sporadic and dependent on the services of volunteers and dedicated staff. The Y.M.C.A., Phillips Brooks House, and other organizations of concerned citizens provide counseling, educational and job placement services. However, lack of trained treatment staff within the institution precludes a full scale ongoing coordinated rehabilitation program.

Most county institutions have had quite limited contact with state agencies serving the disabled. Some institutions use the Division of Employment Security for testing or job placement services. Except for a few isolated instances, the services of the Massachusetts Rehabilitation Commission and the Division of Legal Medicine have neither been requested nor received. In 1962, the condition of the county correctional institutions led a special Governor's Commission to recommend their intergration into the state system. Transfer of these institutions has been vehemently opposed by the county commissioners and sheriffs. The Planning Commission is more concerned with the introduction of vocational rehabilitation services into all settings, county and state, than with the reorganization of the Commonwealth's penal system. Yet, it must be recognized that the development of educational, vocational, and treatment programs is not feasible in institutions which have less than 10 to 20 longterm (more than six months) inmates at one time. Whether under the control of the state or the counties, the various houses of correction must undergo drastic changes in terms of upgrading personnel, modernizing physical facilities, and utilizing community resources, if they are to achieve the objective of rehabilitation.

STATE CORRECTIONAL INSTITUTIONS. Five major institutions and three forestry camps are operated by the state Department of Correction. Each of the institutions serves a different purpose and different type of offender. Maximum security institutions holding approximately 1,000 men are located at Walpole and Concord. Eight hundred men are in custody at Norfolk, a medium security institution, and 180 women are housed in a minimum security institution in Framingham. Three forestry camps at Plymouth, Monroe and Warwick, have a daily population of about 150 men. Bridgewater, the largest institution in the system, has approximately 1,600 inmates, including 700 alcoholics, 600 criminally insane persons, and 150 defective delinquents. The prison department and state hospital at Bridgewater contain specialized units for the treatment of alcoholics and sex offenders.

Characteristics of the state prison population indicate that many inmates have vocational problems and are in great need of vocational rehabilitation services. A great majority of prisoners are uneducated, unskilled, and disabled. Medical histories of the inmates disclose many cases of mental illness, retardation and personality disorder as well as physical disability. A study of Concord Farm inmates, conducted by the Department of Correction, found that only 10% of the inmates had regular work records. The great majority were irregular or casual workers who were unable to hold their jobs for more than brief periods of time.

Prison industries and work programs exist in all state institutions, but actual vocational rehabilitation programs are minimal. Work programs are geared to meet the needs of the institution and production rather than the needs of the individual. With the exception of the prisoners at the forestry camps, inmates are rarely employed on a full time basis.

A few vocational training programs are offered in the institutions. A few men participate in apprenticeship training in sheet metal work at Norfolk. Auto mechanics pro-

g .ms exist at Concord and Bridgewater. Federally financed Manpower Development and Training Act (MDTA) programs are planned at Plymouth. All of these programs have developed very slowly and are not available to more than a few inmates.

Juvenile Offenders in the Community

Community programs assume an added significance for the juvenile offender. Individualized justice is central to the philosophy of the youth service law and the juvenile court. Rehabilitation is the only goal and programs are intended to meet the needs of the boy or girl involved. Probation is by far the most frequently used disposition for juveniles. Many other cases are filed and dealt with on an informal basis. Of the 6,470 juveniles appearing in court in 1964, only 872 were committed to the Youth Service Board.

Commitment to the Youth Service Board does not neces sarily result in institutionalization. After study, the Board may utilize a variety of dispositional alternatives including home placement, foster care, and private school placement Approximately two-thirds of the children under the care of the Youth Service Board are on parole status in the community.

The need for community based resources for the juvenile offender and his family has been expressed many times by judges, youth service officials and various study committees concerned with the problem. Effective public programs for juvenile offenders in the community do not exist. Excessive caseloads of juvenile parole agents and juvenile probation officers preclude adequate supervision and guidance for the juvenile.

Juvenile offenders in the community urgently need vocational rehabilitation services, especially counseling, prevocational and training services. Reports of probation officers and others who work with the juvenile offender indicate that many of the juveniles lack educational achievement, and are unmotivated and unrealistic about vocational goals. Particularly pressing is the problem of retarded and emotionally disturbed children who come before the courts and the Youth Service Board.

There has been recognition of the need for vocational rehabilitation services for the juvenile offender in the community. Juvenile probation officers and the Massachusetts Rehabilitation Commission are in the process of developing formal referral arrangements. No such relation has been established with the Division of Youth Service for parolees.

Institutionalized Juvenile Offenders

The Division of Youth Service operates four Detention and Reception Centers and residential institutions and a forestry camp for the care of children adjudicated delinquent and committed to its care. In 1967, 881 juveniles were committed to the Division.

Children committed to the Youth Service Board exhibit many of the same characteristics as the adult offenders. Surveys of all Division of Youth Service institutions conducted by the Planning Commission indicate that all but a few institutionalized juveniles suffer from disabilities which tend to interfere with personal adjustment and potential employment. Superintendents of the Division's detention-reception centers, where each child undergoes medical and psychological evaluation, estimate that 75%-80% of all children received by the Division manifest behavioral disorders.

There are no formal vocational rehabilitation programs in any of the Division's institutions. Some institutions offer vocational education and skill training through institutional work assignments. Work release programs are more highly developed than those in adult institutions. However, it appears that there is little interaction between the institutions and community agencies such as the Massachusetts Rehabilitation Commission and the Division of Employment Security.

In addition to juveniles in institutions operated by the Youth Service Board, there are 200 to 250 juveniles in county training schools in Essex, Middlesex, and Hampden counties. Juveniles are committed to these institutions for violation of truancy laws and other school offenses. Upon reaching the age of 16, they must be discharged.

Programs of the county training schools are predominantly academic with no significant vocational or prevocational services. There has been no interaction between the training schools and the Massachusetts Rehabilitation Commission.

DIAGNOSIS AND EVALUATION

Comprehensive classification of all public offenders is a necessary foundation for correctional rehabilitation programs. Offenders presently undergo a number of different screening and intake procedures. Probation officers prepare presentence reports, parole officers prepare information prior to discharge, and institutions classify inmates in terms of criminal record, age, education and physical condition. In most cases, classification does not include adequate vocational information, and in some cases is nothing more than a perfunctory physical examination and a notation of criminal record.

Ideally, diagnostic information should be available before sentencing. Under federal sentencing procedures, judges are empowered to refer offenders to reception and classification programs for study. A variation of this model exists in Massachusetts for juveniles committed to Youth Service Board detention-reception centers.

A judge's knowledge of the individual should not be limited to criminal record and available data from the presentence report. Disposition of adults as well as juveniles should be based on complete medical, psychological, social and vocational data. When called for, extended evaluation including psychiatric and psychological examinations, trial work assignments and prevocational training should be utilized to evaluate work habits, motivation and functioning, and to determine the best program for the individual.

All offenders should receive comprehensive classification in court clinics, adult institutions, or juvenile centers prior

to sentencing. Regardless of the setting, all screening should be a team function involving vocational rehabilitation specialists and corrections personnel. Comprehensive diagnosis and evaluation of the offender is valuable in a number of ways. Information may be used to determine eligibility for vocational rehabilitation services, to plan educational and vocational assignments, and in updated form, to develop prerelease and parole plans.

PREVOCATIONAL SERVICES

All public offenders should receive comprehensive prevocational services as needed in order to function at the optimum level of their potential. These services should increase the offender's ability to deal in positive interpersonal relationships, to develop social skills, to complete adult basic education, and to undertake the activities of daily living. Individual and group counseling should be provided as well as information on personal grooming and appearance, budgeting income, and social and recreational activities, similar to the program presently provided to youthful offenders in Springfield by Goodwill Industries.

RESTORATION SERVICES

The major facility for offenders in need of medical or physical restoration services is the hospital at the Massachusetts Correctional Institution at Norfolk. This 75 bed hospital, including a physical medici unit and social services unit, serves men transferred from state and county correctional institutions. The Youth Service Board and county institutions use community hospitals, public health hospitals, and other medical facilities when needed.

Increased attention should be given to the medical needs of adult and juvenile offenders, especially in regard to the correction of minor physical defects which may hinder employment and personal adjustment. In addition to providing hospitalization and treatment during the acute stages of illness, agencies responsible for the custody of juvenile and adult offenders should consider the need for restorative services such as speech, physical and occupational therapy. To insure the availability of these services, each correctional institution should be linked to a general hospital designated as the area rehabilitation center.

Development of mental restoration services for offenders in the Commonwealth has been mixed. While significant progress has been made by the Department of Correction and the Division of Legal Medicine in state correctional institutions, mental health services for juveniles have been less than satisfactory. Services for county inmates have been practically nonexistent.

Counseling Service Units in state institutions provide ongoing therapy to many inmates. In 1966, 13% of the overall population were involved in individual and group psychotherapy. A recent evaluation of the psychotherapy program revealed a significant impact in reducing recidivism for those involved in a long term treatment relation. Experiences of state institutions coupled with the need for mental health services in youth service and county institutions, as documented by the Massachusetts Mental Health Planning Project and other groups, indicates that the expansion of mental health treatment services is critical to the development of an effective rehabilitation program. Regionalization of the Division of Legal Medicine under the new organization plan of the Department of Mental Health, should provide the mechanism necessary for the provision of mental health services to all offenders. Special attention should be devoted to giving offenders and exoffenders access to area comprehensive mental health services, as well as developing institutional treatment programs.

VOCATIONAL TRAINING

To be fully effective, vocational training must be preceded by vocational evaluation and followed by a recommendation for placement. In this sense, there is very little vocational training being carried out in the state and county correctional institutions. Apprenticeship training and Manpower Development and Training Act programs have been available to a few inmates, but most leave our correctional institutions without any improvement in work habits or work skills.

Prison industries and institutional work assignments do not fill the void. Under law, inmates can be employed for the benefit of the Commonwealth and to learn valuable trades. In practice, neither objective is accomplished to any significant degree. Based on a century old concept of work as a form of punishment and limited by restrictive legislation of the depression years, obsolete industries operate with more concern for production and the needs of the institution than for the vocational training needs of the inmates. In larger houses of correction, such as Deer Island, where maintenance tasks are insufficient to occupy the inmates, idleness prevails.

Prison industries should be completely overhauled. Obsolete industries, such as those related to woodworking or agriculture should be eliminated. Programs should be restructured to conform to training and placement opportunities in the community. Chapter 127 of the General Laws regulating prison industries should be revised to reflect a vocational training orientation. Such a revision should create a separate vocational training fund and provide for contracts and subcontracts with private industry.

Vocational training within institutions requires competent instructors and modern equipment. Presently, the diversion of prison industry revenue into the Commonwealth's General Fund precludes financing of improvements and conversion of obsolete industries into meaningful training programs. In fiscal 1967, revenues of state prison industries were more than $1.2 million. This money should be retained by the Department of Correction in a separate fund for the development of modern vocational training programs. Funds could also be used to promote work motivation in inmates who currently are employed at a maximum rate of 30 cents per day

Vocational training programs should be financed through a variety of sources including income earned in prison industries, federal-state vocational rehabilitation funds, direct appropriations from the state, and other available public or private funds. Consideration should be given to creating a nonprofit corporation to receive funds from various sources to be used exclusively for the expansion and improvement of vocational training programs.

Large scale sales of prison products to the public and contracts with private industry are presently prohibited by state law and restricted in interstate commerce by federal law. Prison industries are limited to products for state use. Because of the institutions' inability to produce quality goods at competitive prices, the state use system has proved unsatisfactory. One method of improving the quality of prison goods while maintaining a vocational training perspective is to develop contracts with private industry for both training and production of goods. Industries have developed suitable arrangements in other institutional settings, such as workshops in state hospitals. Businessmen have expressed interest in developing similar programs in prisons. Joint prison-industry programs instituted with proper safeguards to avoid exploitation and adverse impact on the community labor force could yield a number of important benefits including the likelihood that institutional training will result in job placement upon release.

Full scale institutional vocational training programs are not feasible in some houses of correction and juvenile institutions where population turnover is high. In these institutions, emphasis should be placed on the development of prevocational work skills and work habits to prepare the inmate for programs such as work-study or on-the-job training upon discharge. This can be best accomplished through structured work assignments coordinated with institutional education programs and in appropriate cases, work release.

RELEASE PROGRAMS

Work release programs have developed slowly in Massachusetts. A day release program for women has existed for more than 40 years and work release for alcoholics in Bridgewater was authorized in 1956. Not until 1966 at Norfolk County House of Correction were the first male prisoners released for gainful employment while under sentence. Since the inception of the program at Norfolk, 216 prisoners have participated. In 1968, all counties were authorized to establish work release programs in houses of correction. Chapter 723, Acts of 1967, authorized day work in the community for certain inmates of the Massachusetts Correctional Institutions at Concord, Norfolk, and Walpole.

A work release program can secure substantial benefits for the inmate and the public by preparing the offender for life in the community. It provides him with work training and allows him to accumulate savings for the support of dependents and for use upon discharge. Experiences at the Norfolk County House of Correction are illustrative of the benefits of a well run work release program. After 15 months of operation, 152 men participated in the program earning more than $62,000 and contributing $24,800 for their room and board and the support of dependents. Only one of the 152 inmates walked away from the job.

During the summer of 1968, a unique program was established between the Massachusetts Correctional Institution at Concord and the Fernald State School. This program enables 16 inmates from Concord to volunteer on a daily basis to work with retarded children at Fernald under the supervision of two assistant directors of the nursing service. During the first few months six men placed on parole were hired as attendants at the school. This cooperative effort (CARVE, The Concord Achievement Rehabilitation Volunteer Experiment, the name chosen by the inmates) is supervised by representatives from Concord, Fernald, the Parole Board, and the regional office of the Department of Mental Health.

Work release should be available to selected inmates in all state and county correctional institutions. To insure implementation of work release, authorization of programs should be accompanied by adequate appropriation for staff. Work release supervisors should be assigned full time to each institution with an authorized work release program. In addition to supervising releases on the job, the work release supervisor should be responsible for processing inmates for selection for the program and contacting employers for work release placements.

Presently, release programs are limited to release for competitive employment. While competitive employment may be the most profitable placement for both the individual and the Commonwealth, many inmates may not be prepared for employment. Other activities such as educational programs, vocational training or work in a sheltered setting may be more appropriate. In this regard, the use of vocational education facilities and community adult education programs should be carefully explored.

An example of what has sometimes been termed study release, was arranged in 1968 between Clark University and the Worcester county house of correction permitting inmates to attend evening classes. Approved by the Community Action Council of Worcester and the County Sheriff, the program allows inmates to travel to and from the university without guards to attend regular classes, utilize tutoring services and, if they wish, work towards a degree.

Another important use of release programs involves allowing those inmates anticipating discharge or parole to visit prospective employers for job interviews. Opportunities to meet face to face with employers in a work setting would enhance placement possibilities and ease the transition from the institution to life in the community.

COMMUNITY BASED PROGRAMS

A rehabilitation residence designed to demonstrate the effectiveness of short term residential programs for offenders should be established jointly by the Parole Board, the Commissioner of Probation, and the Department of Correction. Research and training opportunities should be provided to enable staff to develop and operate additional re-

habilitation residences where needed. The facility would combine the concepts of a probation residence, a halfway house, and a prerelease guidance center into one program.

In addition to developing public rehabilitation residences, agencies serving the public offender should place inmates in existing privately operated halfway houses on a fee for service basis. Private facilities are presently being used for federal offenders and some state parolees. Through use of the purchase of service device, the state will be able to expand its community based programs without the delay and cost of acquiring new facilities.

DISCHARGE AND PLACEMENT

Many offenders who are able to adjust to life in an institution or under the supervision of a parole or probation officer fail to maintain this adjustment when discharged. Although the period preceding and following discharge is most critical for the offender, many are discharged without needed services. There is very little prerelease planning and discharged offenders in need of transitional programs must depend on private agencies for support.

Job placement is perhaps the most important service to be provided upon discharge, yet placement efforts on behalf of the offender have been underdeveloped and placement resources uncoordinated. The Division of Employment Security, the Massachusetts Rehabilitation Commission and the Parole Board all have statewide responsibility for job placement. Among these agencies, only the Parole Board provides specific placement services for the public offender. All 40 parole officers are concerned with job placement of parolees and two parole employment officers devote full time to job finding and job development. However, many public offenders do not come under the supervision of parole officers and are not serviced by the Massachusetts Rehabilitation Commission or the Division of Employment Security. Approximately 40% of offenders in state institutions are released without parole and less than two percent of the 29,000 offenders released each year from county institutions are under the supervision of the state Parole Board.

There is a pressing need to coordinate placement activities. The Division of Employment Security, the Massachusetts Rehabilitation Commission, the Parole Board, the Commissioner of Probation, and the Department of Correction should develop formal cooperative agreements outlining the responsibilities of each agency in job finding, job counseling, and job placement and followup for all public offenders. Such agreements should include guidelines for referral, mechanisms for exchange of employment data and arrangements for continuing liaison among agencies. Development of formal relations should be guided by the principle that the Parole Board retains the ultimate authority for decisions regarding parolees and should participate in all decisions prior to parole which may effect job placement on release.

Many inmates of county houses of correction do not come under the jurisdiction of the Parole Board and are discharged without supervision. In these cases, it is essential that the inmates receive employment counseling and placement assistance prior to discharge. The Division of Employment Security should assign employment counselors to meet the needs of these offenders. Experience has shown that one employment specialist working closely with institutional personnel can accomplish a great deal. Collaboration between the Division of Employment Security and the Worcester County House of Correction resulted in the placement of 159 inmates during the first nine months of 1967. Similar programs should be initiated in each county.

Job placement is an important objective for juvenile as well as adult offenders. In many cases, the juvenile on parole is not ready for job placement. In other cases where educational achievement and job skills are adequate, he may fail because of difficulty concerning personal adjustment and social relationships. In such cases, further acts of delinquency may be prevented by additional support from community agencies such as the Division of Employment Security and the Massachusetts Rehabilitation Commission. The Division of Youth Service in conjunction with the Division of Employment Security and the Massachusetts Rehabilitation Commission should expand prerelease and postrelease programs aimed at providing youths with awareness of occupational, training and supportive services in the community.

Although it is necessary to improve services to adult and juvenile offenders at discharge or parole, services initiated at this stage without prior evaluation or vocational planning are not likely to yield impressive results. Placement and support upon discharge must be considered as links in the continuum of correctional rehabilitation that begins with classification immediately after adjudication.

Adequate vocational training programs and appropriate job placements are the most suitable ways to increase employability of offenders. However, well prepared and able individuals have been deprived of employment opportunities simply because of the stigma of criminality or delinquency. Adverse public attitudes toward the employment of offenders serve to block rehabilitation efforts generally and in certain instances, manifest themselves in specific restrictions on employment opportunities. The Attorney General's Advisory Committee on Juvenile Crime reported that the Board of Barber Registration severely restricts the training of barbers at the Youth Service Board's Industrial School for Boys. Similar restrictions limit the scope of apprenticeship training at state correctional institutions.

Overcoming negative attitudes to employment of exoffenders is part of the larger issue of promoting public awareness of the need for a rehabilitation approach to crime prevention. In an effort to improve public awareness and develop public support of rehabilitation programs, correctional agencies should work closely with labor and industry to identify and remove obstacles to the employment of exoffenders and discharged deliquents. The role of labor and industry in rehabilitation of public offenders should be fully developed by establishing a Council of Cooperating Employers and Labor Unions within the Governor's Advisory Committee on Correction in cooperation with all agencies serving adult and juvenile offenders. This Council should be given the specific mandate to review training, work and

placement programs in institutions, to advise institutions on the development of new programs, and to encourage the employment of public offenders.

PUBLIC OFFENDER SERVICES WITHIN THE MASSACHUSETTS REHABILITATION COMMISSION

'gr nts of vocational rehabilitation services are ame . h. services presently provided by agencies dealing with the public offender. Diagnostic study at a youth service reception center or court clinic, corrective surgery at Norfolk, work release at Framingham or Dedham, job placement by probation or parole officers, may all be considered as part of the vocational rehabilitation process. Despite these services, which may be characterized as partial vocational rehabilitation, there is no coordinated process of vocational rehabilitation for the public offender. Services are not identifie s vocational rehabilitation, much less coordinated with one another. There is an urgent need to give direction to existing services as well as to develop new programs. The position of Supervisor of Programs for Public Offenders should be established within the Massachusetts Rehabilitation Commission to meet this need.

Orderly expansion of the role of the Massachusetts Rehabilitation Commission in the rehabilitation of public offenders requires a high level specialist to develop, direct and coordinate vocational rehabilitation programs in correctional institutions and in the community. In addition to channeling vocational rehabilitation services into correctional settings, the Massachusetts Rehabilitation Commission should consult with youth service and correctional agencies in developing vocational programs.

The Massachusetts Rehabilitation Commission program supervisor should stimulate the flow of information concerning vocational rehabilitation of the public offender. Perhaps the most formidable obstacle to coordinated programs is the minimal communication among agencies and the lack of knowledge on the part of both vocational rehabilitation staff and correctional personnel concerning each other's programs and services. Special efforts must be made to overcome the reluctance of vocational rehabilitation counselors to work with disabled criminals or exconvicts who are perceived as poor risks for rehabilitation.

One of the most important functions of the Massachusetts Rehabilitation Commission program supervisor will be the development of cooperative agreements with correctional agencies involving the use of third party funds for vocational rehabilitation. In 30 states, including the neighboring states of Connecticut, New Hampshire and Vermont, the vocational rehabilitation agency has developed formal agreements for the provision of vocational rehabilitation services to public offenders. The Massachusetts Rehabilitation Commission should enter into cooperative agreements with the Commissioner of Probation, Parole Board, Division of Youth Service, Department of Correction, individual court clinics, and the larger houses of correction. While differing in detail, each interagency agreement should provide for the use of federal vocational rehabilitation funds under the supervision of the Massachusetts Rehabilitation Commission in correctional settings for vocational rehabilitation services. Federal funds should be matched in kind through the use of existing staff and resources for vocational rehabilitation. Use of this device will allow the state to expand the vocational rehabilitation component of correctional treatment while bearing only one fifth of the cost of new services.

In addition to developing cooperative agreements for the use of federal funds for vocational rehabilitation services, the Massachusetts Rehabilitation Commission should work with correctional agencies to take advantage of special federal grant programs, such as those for research and demonstration, sheltered workshops, and expansion of vocational rehabilitation services.

Just as important as obtaining new grants is the task of translating the findings of completed projects into the regular vocational rehabilitation program. The Social and Rehabilitation Service has funded more than 30 research and demonstration projects involving public offenders throughout the country. Many of these projects demonstrated the effectiveness of providing vocational rehabilitation in a variety of correctional settings. Procedures tested in these projects could be put into practice in Massachusetts without delay. Utilizing these results, the Massachusetts Rehabilitation Commission should expand its programs to provide comprehensive vocational rehabilitation services to all state and county correctional institutions.

INTERAGENCY APPROACHES

Agencies responsible for the public offender are concerned with the objective of rehabilitation. An array of medical, psychological, social, and educational services, many directly related to employment, are provided to achieve the same end. Yet, it is not known how these services complement one another or actually have any effect on the disabled offender. No permanent mechanism exists for the coordination of services. No plans exist to relate correctional programs to newly developing community programs in mental health, retardation and public welfare. No cooperative arrangements exist for dealing with common concerns such as research, professional manpower development, and public awareness. Lack of communication and the isolation of some parts of the system lead to a duplication of staff functions and gaps in service to the offender.

A beginning recognition for the need of a comprehensive approach to the problem of crime prevention and law enforcement prompted the creation of the Governor's Public Safety Committee, by Executive Order in 1966. Supported in part by a federal grant from the Office of Law Enforcement Assistance, the Committee is developing specialized subcommittees to deal with various problems of law enforcement and criminal justice. Recent legislation making the Committee a permanent agency and designating it as the Governor's Committee on Law Enforcement and the Administration of Criminal Justice, makes it the logical agency for coordinating rehabilitation programs In 1968, the Com-

mittee was designated by the Governor as the state's agency for comprehensive law enforcement, juvenile delinquency, and corrections planning

To plan and coordinate the rehabilitation efforts of all agencies working with public offenders, the Governor's Committee on Law Enforcement and Administration of Criminal Justice should establish a Subcommittee on Rehabilitation. This Subcommittee should be composed of representatives of private and public vocational rehabilitation agencies, the Division of Employment Security, and representatives of the Parole Board, Commissioner of Probation, Department of Correction, Division of Youth Service, Division of Legal Medecine, county correctional institutions and voluntary correctional agencies.

While working towards a goal of comprehensive and coordinated programs for the rehabilitation of public offenders, the Subcommittee on Rehabilitation should give priority to those areas where independent programs lead to duplication of effort. Priority areas of concern should include research, recruitment and training of professional manpower, and public awareness programs.

The value and use of comprehensive rehabilitation programming in the area of crime prevention should be expanded through increased public awareness, education and information services. Staff responsible for providing public awareness support to all agencies serving the public offender, should be located in the Governor's Committee on Law Enforcement and Administration of Criminal Justice.

Pride, fear, and confusion are stopping 5 million disabled from getting the help they need.

Five million disabled people are in need of our help. And we can't find them. Either they don't know where to go for help or they won't go.

Some are disabled physically. Others mentally. Some are living in the past. Others, disabled from birth, have no past.

But most, with proper guidance and medical aid, could be living instead of existing. They could be learning to take care of themselves. They could be taught interesting jobs. They could be getting more out of life than they're getting.

So if you're disabled (or concerned about someone who is), write to us for help.

You've got nothing to lose but your disability.

What's stopping you!

Write: Help, Box 1200, Washington, D.C. 20013

REHABILITATION OF THE HANDICAPPED CAMPAIGN
MAGAZINE AD NO. REH-1-69-7" x 10" (110 Screen)

WORKMEN'S COMPENSATION AND REHABILITATION

RECOMMENDATIONS

NOTICE OF RIGHTS

142. To provide injured workers with needed information regarding workmen's compensation and rehabilitation, the Industrial Accident Board should mail to each injured worker a brochure which explains in simple language his rights under the law and also gives locations where he can receive further information.

REHABILITATION PENDING ADJUDICATION

143. The Industrial Accident Board should authorize injured workers to begin rehabilitation programs with the Massachusetts Rehabilitation Commission in contested cases, without waiting for a final determination as to the employer's or insurer's liability. If liability is found to exist, the employer or insurer should be required to reimburse the Commission for its expenses.

LUMP SUM SETTLEMENTS

144. To encourage the rehabilitation of injured workers, the workmen's compensation law should not permit lump sum settlements of claims unless the Industrial Accident Rehabilitation Board has determined that the lump sum payment is essential to the injured worker's rehabilitation.

SUBSEQUENT INJURY FUND

145. To facilitate the employment or reemployment of disabled workers, the subsequent injury provisions of the workmen's compensation law should be expanded from injuries occuring to limbs or eyes to include all preexisting physical conditions.

APPROVAL OF REHABILITATION FACILITIES

146. Statutory responsibility to maintain a list of rehabilitation facilities approved for use by injured workers should be transferred from the Industrial Accident Rehabilitation Board to the proposed state Rehabilitation Facilities Board

THE WORKMEN'S COMPENSATION SYSTEM

Workmen's compensation laws were enacted by most states in the early part of the 20th century to provide a more satisfactory method of handling the cases of workers injured in occupational accidents. These laws replaced the traditional approach of a personal injury law suit based on the negligence of the employer. It had become apparent that proving the employer's negligence was too costly, slow, and uncertain. In addition, the employer's defenses — contributory negligence, assumption of risk, and negligent acts of fellow workers — made recovery even more difficult.

In essence, workmen's compensation laws require the employer to assume the costs of occupational accidents without regard to fault, as a cost of doing business. The objectives of these laws were to provide the injured worker with a regular weekly income while he was out of work and to pay for his medical and rehabilitation expenses, as well as to encourage employer interest in occupational safety, to eliminate wasteful litigation and legal fees, and to reduce the burden on public and private welfare agencies.

In Massachusetts, the workmen's compensation law is administered by the state Industrial Accident Board, the governing body for the Division of Industrial Accidents. In 1963, the latest year for which statistics are available, 231,464 occupational injuries were reported to the Division.

NOTICE OF RIGHTS

A program to increase public awareness of the workmen's compensation and rehabilitation system is a missing element in present administrative practices of the Industrial Accident Board. Too often a worker is injured, perhaps confined to a hospital, and neither he nor his family know where to turn for help. The employee and his family may suffer undue financial hardship because they fail to receive the benefits to which they are entitled. In other cases, the worker may never seek adequate medical or vocational rehabilitation because of a fear that receipt of such services might jeopardize his compensation benefits.

To minimize the occurance of these tragedies, the state Industrial Accident Board should initiate a comprehensive program of public information and education in keeping with the recommendations of the National Institute on Rehabilitation and Workmen's Compensation. The Board should prepare a brochure which explains in simple language, an injured worker's rights to financial compensation, medical treatment, and vocational rehabilitation. The brochure should be written in general terms and should not attempt to provide information concerning specific services or dollar amounts for particular injuries. The Board should mail a brochure directly to each injured worker promptly upon receiving the employer's first report of injury. A listing of offices where an injured worker can obtain further infor-

mation about compensation, treatment, and rehabilitation should be included in the brochure. The estimated annual cost for the distribution of 250,000 brochures, including printing, postage, and clerical services, would be approximately $50,000.

As a supplement to the brochure, the Industrial Accident Board should provide improved information services to injured workers. The Industrial Accident Board should be more than just an adjudicator of cases; it should help all injured workers get the information and the services to which they are entitled. To implement this program, the Industrial Accident Board and the Massachusetts Rehabilitation Commission should consider the feasibility of using Massachusetts Rehabilitation Commission area offices as information centers for injured workers and their families. In addition, the Board should institute a public education program which utilizes the mass media to inform the general public about the workmen's compensation and rehabilitation program. The proposed Communications and Education Unit of Massachusetts Rehabilitation Commission should assist the Industrial Accident Board in the performance of these functions.

The value of a public awareness program cannot be overemphasized. It is the best guarantee that no injured worker will lose what is rightfully his, because of a lack of information or misinformation. The workmen's compensation and rehabilitation program should be known and understood by all working men.

REHABILITATION PENDING ADJUDICATION

In several thousand cases each year, an injured worker's claim to compensation or treatment is contested by the employer or insurer. In such a situation the case is adjudicated by a member of the Industrial Accident Board. Presently, however, the backlog of contested cases is so great that injured workers have to wait eight months or more before their cases will be heard. If either party is unsatisfied with the decision, appeals can be taken to a board of review and subsequently to the courts which extend the waiting time still further.

During this long delay, the worker's condition may be deteriorating. He may need continuing physical therapy or other medical rehabilitation services which he cannot afford, but which he has a right to receive once he can establish his claim. In addition, serious psychological difficulties may be developing. He may be losing his desire to work and his work habits. Instead, he may be developing new habits such as learning to live on a smaller income, watching large amounts of television, and depending on his wife to work. He may also be losing his pride and his self respect.

For these reasons, the worker should complete his medical treatment and begin work or work training as soon as possible. However, under present administrative procedures, the Industrial Accident Board does not refer cases to the Massachusetts Rehabilitation Commission while they are being adjudicated. An interagency agreement should be worked out to permit such referral, without waiting for a final determination as to liability. Under this agreement, chances for maximum rehabilitation would be markedly improved.

Expenditures in these cases should initially be paid from federal-state vocational rehabilitation monies. Later, if it is found that the worker's injury is covered by the workmen's compensation law, the insurer or self-insurer should then be required to reimburse the Massachusetts Rehabilitation Commission. Statutory provisions requiring such reimbursement should be enacted, if necessary.

LUMP SUM SETTLEMENTS

A major purpose of the workmen's compensation movement was to substitute for the uncertainties and delays of litigation, a system which would provide the injured worker and his family with a regular weekly income to replace his loss of earnings. Today, however, in a large percentage of cases lump sum settlements are made in lieu of the weekly amount.

To the worker, the possibility of a substantial sum in cash may have a great appeal. In addition, the claimant could be informed that if he does not accept the offer of a lump sum, his claim will be contested and he will then have to wait many months for a hearing. A lump sum payment often means that the injured worker settled for a much smaller amount than he might receive through weekly payments. Once a settlement is made, the case is closed. The employer or insurer is released from any further liability if the worker's condition should worsen and, of course, has no interest in the injured worker's rehabilitation.

The practice of "lump summing" has been widely criticized for a number of years. The 1948 report of the proceedings of the International Association of Industrial Accident Boards and Commissions stated that lump sum payments should not be granted except to facilitate the worker's rehabilitation. In 1962, the National Institute on Rehabilitation and Workmen's Compensation recommended that no lump sum settlements be allowed unless the workmen's compensation agency approves the settlement on the advice of the state vocational rehabilitation agency or the rehabilitation unit within the workmen's compensation agency.

Although all lump sum settlements must be approved by the Industrial Accident Board (G.L. c. 152, § 48), pressure from claimant's attorneys as well as from employers and insurers usually results in routine approval of all such settlements. For this reason, the workmen's compensation law should be amended to require that the Industrial Accident Rehabilitation Board determine that the lump sum payment is essential to the injured worker's rehabilitation prior to approval by the Industrial Accident Board.

It is unsatisfactory to maintain that the compensation belongs to the injured worker and that he should be able to determine for himself whether he wants a lump sum payment. In actual practice, the worker's freedom of choice may be severely restricted because of a lack of money and the long delay prior to any hearing on his claim. In addition, there is also the public interest in preserving the workmen's

compensation system of providing a regular income during the period of disability and in seeing that the worker and his family do not become public welfare dependents once the lump sum is used up. If the worker is prepared to use the capital to establish a small business or any other alternative means to become self supporting, the settlement should be approved. However, if the purpose is to compromise a "disputed" liability, or is for the convenience of the employer or insurer or the claimant's attorney, it should not be permitted.

SUBSEQUENT INJURY FUND

Subsequent injury funds are a part of the workmen's compensation laws of all but four states. These funds were established to encourage the hiring of the physically handicapped by reimbursing employers for any increased costs in cases where subsequent injuries combine with an existing handicap to produce a greater disability than that caused by the second injury alone.

Generally, the subsequent injury employer pays compensation based on the disability caused by the subsequent injury alone. However, the employee receives benefits based on his total disability with the difference coming from the subsequent injury fund. Massachusetts law provides for a slight variation from this procedure. In all cases, the subsequent injury employer pays half the total compensation and the fund pays half (G.L. c. 152, § 37). Financing for the fund comes from payments made by employers or insurers in cases where a worker is fatally injured but leaves no dependents to be compensated.

Although Massachusetts adopted the subsequent injury principle in 1919, its coverage is still quite limited. Both the preexisting and subsequent injuries must involve the loss of, or permanent incapacity of a limb or an eye. For all other injuries, diseases, or physical conditions, the subsequent injury provisions do not apply. This narrow scope may cause an employer to refuse to hire handicapped persons such as former cardiac patients because of the fear that they might die on the job, requiring the employer to pay full death benefits.

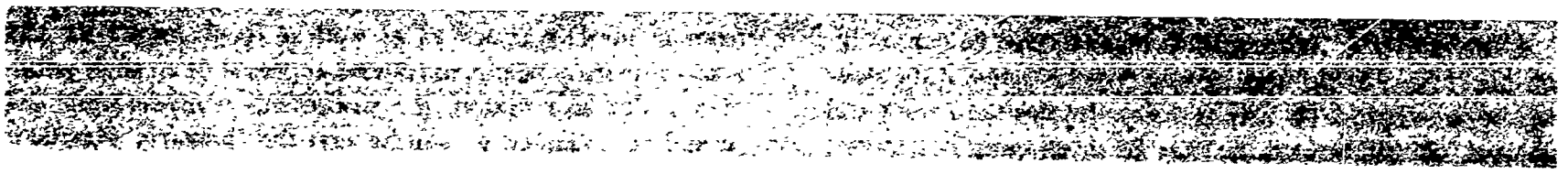
To encourage the employment or reemployment of disabled workers, the subsequent injury provisions should be expanded to include all preexisting permanent physical impairments whether resulting from accidents, disease or congenital condition. Similar provisions are a part of the Model Workmen's Compensation and Rehabilitation Law promulgated by the Council of State Governments, and the recommendations of the National Institute on Rehabilita ion and Workmen's Compensation.

APPROVAL OF REHABILITATION FACILITIES

The Industrial Accident Rehabilitation Board is composed of the Chairman of the Industrial Accident Board, the Commissioner of Rehabilitation and five members appointed by the Governor. The Board meets one evening each week throughout the year to evaluate individual rehabilitation plans for injured workers which have been prepared by Massachusetts Rehabilitation Commission counselors.

Under Chapter 142, Section 30A of the General Laws, one of the Board's duties is to maintain a list of qualified rehabilitation facilities for use by injured workers. This responsibility is difficult for the Board to fulfill because of its part time nature as well as its lack of any technical staff. The Board as presently constituted is not capable of conducting evaluations of the Commonwealth's many rehabilitation facilities.

This duty should be transferred from the Industrial Accident Rehabilitation Board to the proposed Rehabilitation Facilities Board. With its duties of establishing standards and rates for the purchase of rehabilitation services by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, the Rehabilitation Facilities Board should be able to maintain such a list with relatively little additional effort or expense. The expanded Rehabilitation Facilities Units of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should provide staff assistance to the Rehabilitation Facilities Board in the performance of this duty in addition to their other responsibilities.



TECHNOLOGICAL CHANGE AND OCCUPATIONAL PATTERNS

RECOMMENDATIONS

MANPOWER POLICY AND DEVELOPMENT UNIT

147. To achieve coordinated and effective state planning and policy development for job opportunities and manpower problems, a manpower policy and development unit should be established in the state Executive Office of Administration and Finance, Office of Planning and Program Coordination.

148. This unit should provide the Governor adequate staff support to develop policies and evaluate programs related and relevant to manpower issues by developing and keeping up to date a comprehensive state plan, establishing liaison with federal and local manpower programs, stimulating and evaluating research and by stimulating new jobs.

ADVISORY COMMITTEE

149. An advisory committee on manpower policy and development including social scientists, educators, economists, industrialists, labor leaders, social workers, rehabilitation counselors, and other professionals and community leaders both within and outside federal, state and local government should be appointed by the Governor to review and recommend policy to the proposed manpower policy and development unit.

TECHNOLOGY MODIFIES, DISRUPTS, ELIMINATES AND CREATES

Technological change, including the methods and techniques of producing goods and services as well as the involvement of organizations and individuals, is increasingly affecting all individuals, groups and communities. As the tempo of technological change increases, individuals who are occupationally handicapped are especially affected but the rapid changes will affect everybody in the decades ahead.

As changing technology modifies, disrupts, eliminates and creates new jobs, the opportunity for people to participate in a personally meaningful occupational role will be less attainable unless more effective and flexible approaches are designed to make full use of the individual's skills and talents. How to achieve the maximum potential of technological change while keeping the threats minimal is the problem.

Almost certainly, the tempo of technological change will not slacken in the decade ahead. Most importantly, planned and rational activities to cope with technological change must be seen as a continuing regular and normal adaptive response by all segments of the society to deal with a phenomena increasingly evident and potentially affecting everyone.

OCCUPATIONAL HANDICAPS AS A SOCIAL CONCEPT

In the words of the President's 1966 *Manpower Report*, the goal of manpower policies should " . . . lead us to a society in which every person has full opportunity to develop his — or her — earning powers, where no willing worker lacks a job, and where no useful talent lacks an opportunity."

Disability includes physical, emotional and socioeconomic components. Many studies of handicapping conditions indicate a close relation between illness, inadequate use of health services, underutilization of rehabilitation services, and socioeconomic class. However, the concept of *disability* must include society's response to the individual's *disability* if a more comprehensive and more useful concept is to emerge.

Individuals and organizations concerned with providing rehabilitation services usually focus on the means necessary to rehabilitate individuals who are *disabled*. From the viewpoint of technology's impact upon occupational patterns, a society is *disabled* if it fails to make full social use of the talents, skills, and potential of individuals in ways that contribute to the development of society, through occupational roles that are personally meaningful to the individual. Essentially, guaranteed meaningful employment is the right of individuals, and society is *disabled* if it fails to provide this opportunity. However, merely opportunity may not be enough. A special program may be required to stimulate and motivate people to seek employment.

A major source of information for predicting the pattern of the economy and job opportunity in the decade ahead was derived from the Report of the National Commission of Technology, Automation, and Economic Progress, a Commission established by the President and the Congress of the United States in 1964.[1] Occupational patterns are likely to change substantially in the decade ahead. The *handicapped* will include persons other than those who are solely physically and mentally *handicapped*.

[1] *Technology and The American Economy* (and Appendices I-VI), the Report of the National Commission on Technology, Automation, and Economic Progress (Washington, D.C.: U.S. Government Printing Office, 1966).

A CLASSIFICATION OF HANDICAPPING CONDITIONS

To plan sufficient and appropriate rehabilitation services, the population requiring such services must be identified. A significant decision involves the criteria by which individuals are viewed as being *handicapped*.

A simple but useful definition of *handicapped* is *disqualified*. When coupled with the term vocational, this definition suggests that some attribute or absence of an attribute is deemed essential as a requisite for holding a job. If so, how is the attribute acquired? Is the attribute required for specific job holding and/or performance a valid one?

The first question focuses attention on mechanisms developed to impart the attribute to the individual as well as the factors which may prevent the individual from acquiring it. The second question focuses on the validity of declaring the attribute as a requirement for a specific vocational role. Both questions suggest that our response to handicaps require an examination of the environment in which the presently handicapped and potentially handicapped person functions.

A classification of handicap (categorized disqualification) includes the following:

- Physical Disqualification
- Mental Disqualification
- Educational Disqualification
- Age Disqualification
- Income Disqualification
- Environmental Disqualification
- Skill Disqualification

Physical Disqualification

More attention has been paid to persons who are physically disqualified as a result of prenatal experiences or from life encounters and who have a substantial handicap to employment. Until fairly recently, the focus of rehabilitation of the handicapped was on obvious handicaps such as blindness or loss of extremities. However, in the 1950's the federal-state rehabilitation program began to move more extensively into serving those with other conditions such as heart disease. In this period, there was also a marked expansion in services to the mentally retarded and the mentally restored. Under the many existing programs, the aid to the handicapped applies not only to workers but also in many cases to children and housewives who have conditions limiting their activities. Currently, concern with increasing competence in activities of daily living is reflected in rehabilitation programs that aim to restore the family homemaker to productivity in caring for her home and her family, to prepare children handicapped at birth or through later illness or injury, to reestablish social and occupational interests of the elderly, and to increase, for normal schooling, techniques of restoration of physical and mental capacities. Yet, the primary focus of most of the programs is on rehabilitation as preparation for employment.

Estimates derived from the 1962 National Health Survey indicate that approximately 19 million persons, 14 years of age and over, were limited to some extent in their activities because of chronic disease or other impairments. Experts suggest that two million persons could benefit from rehabilitation services. State and territorial public vocational rehabilitation programs receive more than 400,000 new cases per year.

In 1968, Massachusetts served 11,997 individuals through its public supported program and rehabilitated 3,325 into gainful occupations.

Mental Disqualification

Mental handicap refers to a range of disqualifications resulting from a still unclear combination of physiological, psychological and sociological factors that lead to acute or chronic emotional, psychological or behavioral states. The mentally disabled person is unacceptable to those who can offer or withhold occupational opportunities.

Until recently, the primary concern of mental hospitals was custodial care. Various modifications of the care and treatment of the mentally handicapped occurred in recent years. In 1943, vocational rehabilitation programs broadened to include mental as well as physical restoration services with attention to the possibility of rehabilitation and to the prevention of chronicity as well as to making early treatment more available to the total population. The Community Mental Health and Retardation Act enacted by the Massachusetts Legislature in 1966 reflects this change.

Many mentally restored are referred to rehabilitation centers for additional services. In 1966, about 22,000 persons with disabling mental illness were rehabilitated under the federal-state program of vocational rehabilitation. Since the expatient's ability to work and hold a job is one of the most important prerequisites for a stable life in the community, inability to find or maintain employment following hospital release often contributes significantly to the reappearance of symptoms and to subsequent readmission.

Employers are often reluctant to hire former mental patients. Therefore, the very high ratio of unemployment for this group is a matter of special concern.

Mental disqualification is segmented by the lack of skills of many of the mentally restored. In addition, many of the mentally ill never develop good work habits or the ability to communicate with others.

A number of programs, including sheltered workshops, provide adjustment training for expatients and for those not yet discharged. However, such programs are still much too limited to serve all the adult patients who could benefit from them.

Educational Disqualification

Inadequate and inferior education is one of the major elements in the total underemployment and chronic unemployment problem facing people. Educational handicaps

largely explain the high proportion of employed workers in poverty pockets who are in low skilled, low paid jobs and is directly related to unemployment rates.

Employers require high school diplomas for most white collar jobs and for apprenticeships in skilled trades and often for service and semiskilled jobs. This requirement may produce another handicap because the level of education may have little relevance to the tasks performed.

Deficiencies in educational opportunities are still extreme among young people, particularly in impoverished areas. According to the Governor's Commission on the Los Angeles riots, the citywide school dropout rate for former ninth grade students was 30% in 1965, but in three predominantly Negro high schools in south central Los Angeles, two-thirds of the student body dropped out before graduation. Educational deficiency is also reflected in overcrowding and double sessions prevalent in the schools in many large urban areas. Particular emphasis must be given to the fact that the low proportion of high school graduates among slum residents is not a true picture of their educational deprivation. A large gap exists between years of school completed and actual level of educational achievement among the racial and ethnic groups which make up a large proportion of the slum population.

Age Disqualification

Age disqualification represents a handicap derived from the presumed lesser capabilities of the body, mind, and skill performance of individuals within certain age groupings, and the social preference of many industries and datekeepers to occupations for employees within specific age ranges. In periods when labor is scarce, age handicap lessens for both the young and the old. In times of labor surpluses advancing age or youth become a heightened basis for disqualification.

Age handicap has three distinct profiles; the middle years, the aged and the youth.

For the middle years and the aged, the disqualifying attribute is not linked to behavior, attitudes, or capabilities of an individual but to the amount of time that individual has lived. Society fails to utilize available skills and through arrangements, such as forced retirement, imposes this age handicap on the individual.

Disqualification due to youth was a serious problem in 1966. Teenage unemployment in that year was 13%, more than three times as great as for all workers. If the demands of the armed forces had not increased sharply in 1966, the competitive job situation for young workers would undoubtedly have been worse.

Among nonwhite teenage boys, the rate of unemployment declined more slowly in recent years than for whites. The very high rate for nonwhite teenage girls has actually remained unchanged since 1964. One fifth of all nonwhite teenage boys in the work force were jobless in an average month in 1966 as were nearly one-third of all nonwhite teenage girls. An above average rate of unemployment for young entrants into the labor force and for reentrants is to some extent inescapable, but their unemployment is not merely transitional, short duration joblessness. Long term unemployment is highest for teenagers, nearly three times the rate for adult workers.

Income Disqualification

Poor diet, poor environment and poor health habits are all associated with low income and may be responsible for the higher prevalence of chronic handicaps among lower income families. Conversely, because of early diagnosis in treatment resulting from better medical care, lower proportions of the population and higher income groups have chronic physical conditions which restrict activities. Because persons with higher incomes are less likely to work at jobs requiring strenuous physical activity, they may also be better able than persons in lower income families to continue working despite chronic handicaps. In addition, since the poor are much less likely to receive treatment, their job performances may be disproportionately affected by illness.

Thus, it is clear that the lower the family income, the higher the incidence of chronic health conditions which result in reduced activities. Even though the proportion of persons with chronic handicaps increases with age, within each age group, these proportions decrease as the family income rises.

Environmental Disqualifications

Environmental handicaps may be seen as a disqualification resulting from the development of poverty pockets, shifting geographical patterns of employment and changes in the structure of occupations. Disqualification may also be seen as the failure of the society to provide stimulus and support for the development of individual talents and skills. Sources of environmental disqualification are social arrangements providing individuals and groups with inadequate education and motivation for developing skills, failure to provide health and housing resources to nurture the organism; and a failure to provide a sense of opportunity for achievement by allowing or producing social and individual discriminatory practices to suppress aspirations.

This handicap particularly affects those who live in urban slums and some rural areas.

Though it cannot be estimated precisely, subemployment of slum residents is believed traceable to chronic health problems and disabilities. In the 1967 Manpower Report of the President, 10 to 20% of underemployed individuals were estimated to have health problems. Testifying to the intimate relations of a variety of handicaps, the report states that Negroes not only suffer the most from inadequate health care, poor nutrition, and poor living conditions, but can less often qualify for white collar and other jobs suitable for workers with limited physical handicaps.

Skill Disqualification

For the many men qualified only as laborers, the employment outlook is bleak. Employment in such jobs is declining relative to total employment in the United States. Opportunities in other blue collar jobs are also growing much less rapidly than white collar employment. Though service occupations are expanding, offering some additional opportunities for those qualified as laborers, too often the jobs available are in the least attractive positions. According to the Manpower Report of the President, 1967, 40 to 50% of unfilled jobs were in the white collar occupations, while openings were relatively few in the service, laborer, and operative jobs. This pattern is also true for Massachusetts. In fact, most of the unemployed in the lower socioeconomic groups do not have the occupational background called for by most of the present job openings. In the sphere of wasted manpower potential, the most difficult problem is employment in skill levels below the capacity of the worker; another dimension of skill handicap. Though no attempt has been made to systematically measure the number of persons working in jobs below their acquired or potential skill levels, many examples were noted from special studies developed by the U.S. Bureau of Labor Statistics. Teachers have worked as sales people because of local imbalance of labor supply. In times of slow economic growth, skilled craftsmen have worked as dock workers or handymen. College graduates have worked as clerks. Problems of underutilization are most acute among Negro workers.

Another dimension of occupational handicaps results from skill obsolescence. To a large extent, this results from the outpouring of major discoveries and innovations in science and technology. Accumulation of knowledge appears to be so rapid, that there is some concern regarding the ability of scientists and engineers to keep up-to-date in their field to the extent required for really effective functioning in research, development and design work. Comprehensive information is not yet available on the extent of this problem nor on the factors contributing to it.

TECHNOLOGY IN THE DECADE AHEAD

While the National Commission on Technology, Automation and Economic Progress did not deny the existence of serious social and economic problems which might result from technological change, the report dissented from this view. Evidence gathered by the National Commission led to the belief that the basis for any sweeping pronouncements about the speed of scientific and technological progress was inadequate, even though the pace of technological change increased in recent decades and may increase in the future. Further, the National Commission felt that a sharp break in the continuity of technical progress had not occurred, nor was it likely to occur in the next decade.

This point of view argues that technological change, as it is evidenced today, is part of a general pattern of change which has been with us for some time. However, the rate of change is increasing and at a more rapid pace, and is more pronounced in some industries and geographic regions than in others.

Evidence for this point of view is found in indices of productivity and productivity groups, particularly output per man hour (the volume of final output of goods and services produced in a year divided by the number of man hours worked in the year).

In the 35 years before the end of World War II, output per man hour in the private economy rose at a rate of 2% a year. Between 1947 and 1965, productivity in the private economy rose at a trend rate of about 3.2% a year. The significance of these statistics is that anything that grows at 2% a year doubles in 36 years; anything growing at 2.5% a year doubles in 28 years, while anything growing at 3% a year doubles in about 24 years. When the product of an hour of work doubles in 24 years — not much more than half a working lifetime — it is hardly surprising that people feel that their environment is in some kind of continuing flux.

Another indicator, which provides some clues to the growing rate of technological change and which implies that complacency must be rejected, is the time lapse between the birth of a new scientific or technical idea and its commercial application or acceptance. Studies indicate that the time elapsed between technical discovery and commercial recognition fell from about 30 years before World War I to 16 years between the wars, and to 9 years after World War II. Additional time required to convert technical discoveries to initial commercial application decreased from about 7 to about 5 years. Most technological discoveries which will have a significant impact within the next decade are already in an identifiable stage of commercial development.

Rapid introduction of the computer into process control in American industry is another indicator of increasing technological change. In 1954, there were three process control installations in American industry. In 1964, there were 300 installations. By 1970, there will be 4,000 process control computers in American industry. Advent of this new technology most concerns some students of the social impact of technological change since industries that employ the computer in process control also have the greatest displacement of the labor force.

But, one must distinguish between the displacement of particular workers at particular times and places, and unemployment. Technology eliminates jobs, not work, and is a major factor in displacement and in the temporary unemployment of particular workers. Technology affects precise places, industries, and people so as to cause unemployment and apparently does not decrease overall employment levels.

THE IMPACT OF TECHNOLOGICAL CHANGE UPON EMPLOYMENT IN THE NEXT EIGHT YEARS

Given the projective growth of the labor force, 88.7 million persons should be gainfully employed in 1975, about

18.3 million more than in 1964, and an average annual increase of nearly 1.7 million.

A variety of patterns of economic growth can be assumed depending on shifts in investment and consumer expenditure patterns and changes in emphasis in government programs. If an extension of basic patterns developed in the post World War II period continues, the following appears to be valid:

- Farm employment is expected to decline by one million. All other employment is expected to increase by more than 19 million.
- Nonfarm goods producing industries, such as manufacturing, mining, and construction will reflect a moderate increase in manpower requirements of 17%, a rate of increase almost faster than the 17 year period of 1947 to 1964.
- Requirements in the service producing sector, such as trade, finance, government services, transportation and public utilities are expected to increase by 38%, even somewhat faster than the previous 17 year period and more rapidly than the goods producing industries. The effect of these industry employment trends will be to continue recent trends in the industrial composition of the economy. Government and services will increase sharply as a per cent of the total as contract construction and trade will also increase. The relative importance of manufacturing and transportation will decline slightly and the relative size of agriculture and mining will continue to decline sharply. As a whole, the goods sector will decline from about 41% of total jobs in 1964 to 36% in 1975, while the service sector will increase its share of manpower requirements from 59% to 64%.

Occupational requirements of the economy will change substantially as a result of both differential growth rates of industry and the technological development and other factors effecting the occupational requirements of each industry.

Technology has the potential to enlarge the capacities of man and to extend his control over the environment. Not only does technology produce more goods, but it provides a possible foundation for creating social equality among groups. In 20 years since World War II, the annual output of the American economy increased from 212 to 676 billion dollars (adjusted for 1965 dollars, from 394 to 676 billion dollars). This movement from relative scarcity to relative affluence provides this society with an unprecedented array of choices. Society can ask, what can our society have? How does society decide what it wants? and how can it get what it wants? Alternatives are available.

SCARCITY TO AFFLUENCE

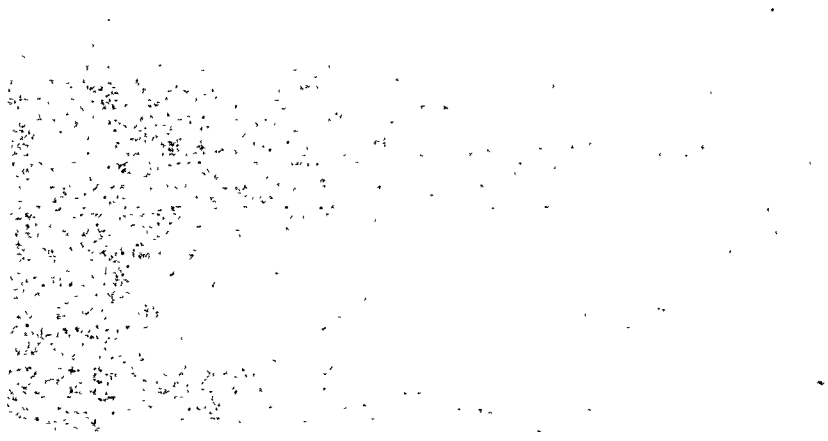
If all the productivity gains in the next 20 years were taken in the form of added income, by 1985 average per capita earnings would increase by 82% from $3,181 to $5,802. If all gains were devoted to more leisure time, by 1985 the work week could fall to 22 hours and it would be necessary to work only 27 weeks of the year. Retirement age could be lowered to 38 years.

Savings from productivity could be used to improve the nature and conditions of the work environment, to reduce monotony in repetitive tasks, to encourage variety and rotation, and in general, to increase the satisfaction in one's work

ECONOMIC PRODUCTIVITY TO SOCIAL UTILITY

Gains in productivity to satisfy unmet community needs by larger public investments is also possible. New technology could be used to increase the effectiveness of learning, to advance diagnostic and treatment approaches to medical care, to experiment with efficient transportation and communication, to clean air and water, to discover and produce comfortable housing, to modify and design attractive and efficient cities, and to improve the quality of American life, in general.

Clearly, technological change will radically alter occupational opportunities. At the same time, the economic wealth that technology produces could provide society with the means for developing its social wealth, its human resources. Because of technological change, the traditional job opportunities available to the handicapped are less likely to be available, even though new and more jobs may be created. New efforts have been undertaken and new efforts need yet to be designed to respond to the situation.



MANPOWER ISSUES IN MASSACHUSETTS

THE NEED FOR MANPOWER PLANNING

Complex social and economic difficulties dictated the need for a manpower planning system. Table I illustrates the comparison of changes in employment patterns in several selected industries in Massachusetts.

Table I
COMPARISON OF EMPLOYMENT IN SELECTED INDUSTRIES IN MASSACHUSETTS, 1950 AND 1966

Industry	*1950*	*1966*	*Percentage Change*
Manufacturing	715,900	694,300	− 3%
Nonmanufacturing Nonfarm	1,045,300	1,400,500	+34%
Service	216,400	383,300	+77%
Textile	118,000	38,600	−67%
Leather	72,000	48,200	−33%

Losses of factory employment were unevenly distributed among the Commonwealth's industries. In general, nondurable goods were worst hit — and within this division, textile employment suffered an almost catastrophic drop and leather products suffered severely. There were other industrial declines, but none numerically so severe as the two mentioned.

Attrition of jobs in industries centered in particular Massachusetts regions and towns. Over the years, the decline helped produce the melancholy and depressed communities — Fall River, New Bedford, Lawrence, Lowell, Haverhill and smaller Massachusetts communities adjacent to the Providence, Rhode Island metropolitan area. Table 2 clearly shows the extent of the attrition on the textile industry and the local community.

Table 2
COMPARISON OF TEXTILE JOBS IN SELECTED MASSACHUSETTS COMMUNITIES 1951 AND 1962

Community	*1951-52*	*1962*	*Percentage Change*
Lawrence	21,100	2,100	−90%
New Bedford	12,130	3,963	−67%
Fall River	12,885	5,363	−58%

Labor shortages in specific occupational groups during 1966 and 1967 mask the prior high unemployment rates encountered in the United States and in Massachusetts. Table 3 illustrates the rising tide of unemployment and Table 4 shows long term unemployment rates increasing.

Table 3
SELECTED AVERAGE UNEMPLOYMENT RATES (UNITED STATES)

	YEARS			
	1953	*1954-57*	*1959-60*	*1962*
Rate	Less than 3%	Never below 4%	5.5%	5.6%

From scanning the tables, we see that joblessness has not been randomly distributed. From these and other indicators, the following groups of workers are among the hardest hit:

- Older persons.
- Very young persons.
- Inadequately educated persons (dropouts).
- Nonwhite persons.
- Women.
- Persons whose skills were rendered obsolete by technological change.

Table 4
LONG TERM UNEMPLOYMENT RATES (UNITED STATES)

	RATES	
Period of Unemployment	*1949*	*1962*
More than 15 weeks	18.8%	28.6%
More than 27 weeks	7.0%	15.0%

FEDERAL MANPOWER PROGRAMS

In response, a great deal of federal emphasis focused upon an attack against structural unemployment. A strategic principle was that people must be made ready to leave declining industries or obsolete occupations by attaining new skills. Therefore, the doctrine of training, or retraining, and attainment of maximum education provided the foundation of federal manpower programs. Response took the form of legislation for, or looking toward:

- Area redevelopment
- Strengthening of the Employment Service
- Extended unemployment compensation
- Benefits for income maintenance
- Wider unemployment coverage
- Improvement of vocational education
  - New facilities
  - Curriculum planning
  - Aid for teachers' training
- Aid to education
  - Loans to institutions
  - Loans to students
  - Work training for students
- Retraining of workers
  - Training of guidance and counseling workers
  - Training for the worker with obsolete skills
  - Training for the first employment
  - Training for training (in how to live in society)
  - Attack on discrimination
  - Creation of new jobs

Every one of these efforts calls for state and local participation in planning and operation as an integral part of its design. Industry as well as government is entreated to take part of the action. Community action and institutional partnership is part and parcel of the operating scheme. This is especially true in education and manpower training.

A truly impressive body of far reaching and well intended legislation exists. However, implementation is inherently difficult, and requires the meshing of many sets of interests and the avoidance or resolution of jurisdictional disputes between differing levels of government and of different authorized programs. A major goal of the manpower policy of the federal government during 1966 aimed at coordination.

Initiated in April 1966, the National State Manpower Development Plan was intended to guide the investment of Manpower Development and Training Act (MDTA) funds. This constituted the start of a planning system designed to ensure that training programs are continually geared to changing job markets and human needs. Policies required the development of state manpower plans which would be reviewed and approved by the federal agencies concerned. Approved state plans were to constitute the plans of operation for MDTA training programs within the state. To guide the states in developing plans for the year, national targets with regard to the number of trainees in institutional, on-the-job and coupled training programs, were specified. Goals were also set for training various groups of disadvantaged individuals, including the handicapped, for training in redevelopment areas and for training to meet skill shortages. Guidelines called for organizing state and local coordinating committees to assist in arriving at local and state manpower development plans geared to the national plan. Coordinating committees were also to advise and assist on matters such as identifying occupational training needs, arranging for specific training programs and recommending the type of training most suitable for certain situations or occupations. Representation on the coordinating committees was to be from all agencies having manpower responsibilities and linked to federal programs including the state employment services, state apprenticeship and training programs, vocational educational institutions, community action agencies, vocational rehabilitation, welfare, economic development and urban facilities planning agencies.

COOPERATIVE AREA MANPOWER PLANNING SYSTEM (CAMPS)

A planning committee made up of representatives of the various agencies dealing with manpower training, convened under the auspices of the Massachusetts Division of Employment Security, formulated the Cooperative Area Manpower Planning System (CAMPS) for Massachusetts. Agencies currently involved in this planning are:

- Massachusetts Division of Employment Security
- Massachusetts Rehabilitation Commission
- Massachusetts Department of Labor and Industries
- Massachusetts Department of Public Welfare
- Massachusetts Department of Education
  - Bureau of Vocational Education
  - Bureau of Civic Education
- Commonwealth Service Corps
- United States Department of Labor
  - Bureau of Work-Training Programs
  - Bureau of Apprenticeship and Training
  - Manpower Administration, Bureau of Employment Security
- United States Department of Commerce, Economic Development Administration
- United States Department of Agriculture
- United States Department of Interior
- United States Civil Service Commission

CAMPS represents a first attempt on the part of the federal government to bring together all the manpower programs developed by a variety of federal agencies. As an initial effort, an arena was provided for these agencies to delineate responsibilities and to discuss their programs at both the federal, the state, and at local (Standard Metropolitan Statistical Areas) levels.

Participation of various agencies in CAMPS was mixed. The program placed added demands on already burdened staff. Some agencies responsible for large scale programs, such as the Massachusetts Rehabilitation Commission, Ac-

tion for Boston Community Development (ABCD), the anti-poverty agency for the city of Boston, made little contribution to the plan in its first year. Many of the difficulties of CAMPS can be attributed to lack of sufficient time and staff to fulfill the mission. Use of Standard Metropolitan Statistical Areas (SMSA's) as the units for CAMPS planning, rather than devising units with rational boundaries, failure to design need indicators, lack of uniform reporting and absence of review and policy recommendations can all be explained by demands to meet a deadline without adequate staff and resources and inflexible guidelines imposed on CAMPS.

However, even granting that staff and time problems could be solved, there are a number of structural weaknesses in the formulation and execution of CAMPS which made comprehensive planning and policy development in manpower impossible. The central weakness of the CAMPS structure involves designating a direct service agency such as the Division of Employment Security as the agency responsible for convening other operating agencies and coordinating the planning effort. The Division of Employment Security has no authority to secure cooperation of other state and local agencies, and in some cases, may be considered as a competitor. As formulated, Massachusetts CAMPS proceeded without the participation of the Governor and failed to bring to bear the influence of the state executive office upon the plan. As a result, the Cooperative Area Manpower Planning System of Massachusetts, as it exists today, is essentially a compilation of existing programs of most federal, state and locally supported manpower programs for the unemployed and underemployed. A gross inventory of resources and listing of programs is insufficient to form the basis of a comprehensive statewide plan with the potential for coordinated programming. Policy formulation requires a plan which incorporates area-by-area profiles of manpower needs and resources, and sets priorities with respect to both programs and geographic areas of the Commonwealth most in need of services. Some of the data are already collected by the Division of Employment Security. In addition, a truly comprehensive manpower plan must include links to the educational, prevocational, social service, and welfare resources of each area.

CAMPS represents a significant idea and laudable first attempt to coordinate and to plan manpower programs. However, to attain fully this desirable goal in a way which defines and applies valid priorities, truly coordinates complex problems, and effectively influences policy development in the manpower and related fields, CAMPS in Massachusetts must be restructured and strengthened.

TOWARD IMPROVED MANPOWER PLANNING FOR MASSACHUSETTS

STATE UNIT ON MANPOWER POLICY AND DEVELOPMENT

To achieve a better integrated, more rational and more effective state policy and plan for expanding and improving job opportunities and manpower programs — both now and for future decades — there must be leadership and direction from the level of the Governor of the Commonwealth. A unit for manpower policy and development should be established in the Executive Office for Administration and Finance — the department charged with overall planning, direction and coordination for the Governor. Such a location is particularly appropriate because of the recent development of a functionally comprehensive statewide planning unit, the Office of Planning and Program Coordination, within this agency.

The four major objectives of this proposed manpower planning unit would be:

- Coordination of manpower policy and plans.
- Development of improved means for matching people with jobs.
- Creation of new occupational roles to fit diverse needs and abilities.
- Continuing adaptation of educational institutions and programs to technological and social changes.

To achieve these objectives, the Office of Manpower Policy and Development should have authority and responsibility for :

- Developing, reevaluating, and keeping up to date a comprehensive state plan to coordinate all manpower programs in light of current and anticipated technological and social change. This state plan should include:
  - An up-to-date survey of the effects of technological change upon the objective of guaranteed employment opportunity for all persons seeking work.
  - An inventory of all state, federal and local manpower and education programs in the Commonwealth.
  - Statewide priorities for the allocation of state and federal manpower resources.
- Reviewing all planned manpower programs in the light of the state plan, and assisting agencies to develop new programs in accord with statewide priorities and needs.
- Establishing liaison with federal and local manpower programs, developing and submitting applications for federal grants relating to manpower and technological change, and assisting state and local agencies and institutions to do the same.
- Stimulating and evaluating research which analyzes and assesses the impact of technological change upon the utilization of the Commonwealth's human resources.
- Defining and identifying new employment roles for citizens and stimulating state programs which create and support such new job roles.
- Promoting coordinated relations among all the agencies

which operate skill training, work experience and education programs and these agencies providing supportive services to disabled and disadvantaged persons.

- Stimulating all state and local agencies in identifying and dealing with issues and problems which are related to manpower policy, plans and development.
- Advising the Governor on the impact of social and technological change on manpower and education programs, and the relation of such changes to other state policies or programs.
- Advising the state's education agencies and institutions of the implications for educational programs, staffing and facilities of the social and technological changes which are occuring or may be foreseen.

Staffing the Proposed Manpower and Policy Development Unit

To staff the proposed manpower and policy development unit with maximum effectiveness, the following initial staff pattern and functi ns are proposed, with the salary ranges necessary to attract the high competent and relatively scarce personnel required:

COORDINATOR OF MANPOWER POLICY AND PLANNING to plan and direct the work of this new unit, to advise the Governor on all manpower activities in the Commonwealth, to be responsible for directing CAMPS activities in Massachusetts, to be the executive officer for the Governor's Advisory Committee on Manpower and to coordinate the manpower activities of all state departments and agencies.

$22,000 - 25,000

MANPOWER PLANNER to develop estimates of future manpower needs of the public and private sectors of the state's economy, including the projection of emerging technologic and social roles and the possible decline of existing roles, and to seek to define and develop new roles, especially those which may be filled by those presently unemployed and underemployed.

$15,000 - 18,000

MANPOWER EDUCATION AND TRAINING COORDINATOR to coordinate the development of training and education programs in the public secondary schools, public higher education, and local and state agency training programs to meet the present and future manpower needs defined by the manpower planner. This task will include developing effective relationships with the training and education programs in the private sector of the economy.

$15,000 - 18,000

Executive Administrative Assistant		7,500
2 Senior Clerk-Typists @ $5,000		10,000
Consultant Services		31,500
(Proposed) Fiscal Year 1970	Total	$110,000

Governor's Advisory Committee on Manpower

In addition to the staff to assist the Governor on matters of manpower program and development, the Governor should appoint a citizen's committee to provide him with expert opinion. This committee should include social scientists, educators, social workers, rehabilitation counselors, economists, industrialists, labor leaders and other community leaders. This committee can screen solicited and unsolicited ideas concerning manpower policy and development. The advisory committee would provide the Governor with direct contact with experts and outstanding citizens who have knowledge, interests and concerns in the manpower area. The committee would be a means to tap ideas, insight and imagination of the total community. A major advisory function should be formalized through the issuance of an annual report which the advisory committee should submit to the Governor and which should be published for wide dissemination.

SELECTED MANPOWER TASKS FOR THE FUTURE

IMPROVING APPROACHES TO MATCHING PEOPLE WITH JOBS

To achieve a better fit between those seeking occupational opportunities and those who manage the distribution of job opportunities, a number of issues must be considered:

- Methods need to be identified and utilized to encourage and reward businessmen to systematically and continuously report information on available jobs.
- Area occupation profiles and parallel industrial resource profiles, both existing and potential, need to be developed to permit activities designed to attract appropriate industries to areas with incipient or potential labor surpluses.
- More effective survey and analytical techniques should be developed to attain an increasingly valid and reliable predictive profile of job opportunities in Massachusetts on a five-year basis. Projections of probable need in particular occupations are an essential guide for vocational education and training and retraining institutions, and for those concerned with the development of policies which will encourage workers to acquire occupationally relevant skills.

Progress toward fuller utilization of the human resources depends increasingly on a many pronged effort to facilitate the employment of groups of underutilized workers, including the handicapped. One obstacle toward achieving this end is the inadequacy of present knowledge about underutilized people and limited knowledge about the relevant characteristics of the unemployed.

Industry Training

Since most training currently takes place in industry, a regular system of detailed reporting on training programs and employment needs in business, industry, and the services would aid greatly in appraising achievement and needs in the field of manpower development and in effective coordination of federal training programs with other employment training activities. The private sector should be encouraged to adopt programs and services which make possible the employment of individuals with requisite skills who are presently unemployed because of special social needs.

Lack of adequate child care facilities may be a serious barrier to employment of women who want, and need, to work. In the President's Manpower Report of 1967, almost one out of every five slum residents not in the labor force and wanting a regular job gave inability to arrange for child care as the principal reason for not looking for work. A greatly expanded day care program for preschool children could permit more mothers to get the jobs that they greatly need and might also be of help to presently working mothers and to their children.

Another obstacle to individuals with requisite skills results from the movement of business and industry away from the central city toward the suburbs. Specifically, individuals who are environmentally handicapped, without either automobiles or money for public transportation, may have little, if any, knowledge of the new industrial plants which may be springing up in the outskirts of their city. Governmental and private sources must devise ways to remove disqualification resulting from the transportation problem. One recent development, made possible by a mass transit demonstration grant from the Department of Housing and Urban Development, was a new busline opened in July 1966 connecting Watts with the industrial area around the Los Angeles airport, and subsequently with another industrial and commercial area. Within two months the line was handling more than 10,000 passengers a week, with the majority either going to work or looking for work. In a similar development, the Massachusetts Bay Transportation Authority (MBTA) recently established an Employment Express to make the Route 128 industrial area accessible to Roxbury residents. The MBTA is committed to two years of operating four buses daily with a one way fare from Roxbury of 50 cents. The project, which is entirely MBTA financed, was conceived and implemented by that agency's Community Relations Office. For several years the Urban League of Greater Boston had surveyed possibilities for such buses, and when the project commenced, the League cooperated by publicizing the MBTA plan. The *Bay State Banner*, Roxbury's weekly newspaper, devoted several articles to the Employment Express, and local personnel programs spread the word. Similar transportation, directly from environmentally disadvantaged areas to expanding industrial areas, developed by industry or government, could help to open more jobs to handicapped individuals. The new model cities program could help to encourage this development.

On-The-Job Training

On-the-job training efforts as expressed in the Manpower Development and Training Act program have many advantages. One is a psychological advantage. On-the-job training carries a paycheck with it rather than an allowance and leads much more directly to continued employment after training. This critically differentiates it from other approaches. Because he is paying wages to the trainee, the employer has a positive interest as well as investment in the project.

An important potential for employing handicapped people is through the development of job training contracts which specifically call for employment of the handicapped. An example of this is a contract with the national nonprofit agency, the Association of Rehabilitation Centers, calling for the development of training programs for 900 persons in nonprofessional occupations, to alleviate the shortages in rehabilitation hospitals and related institutions. Trainees will be recruited from among the disadvantaged and, where possible, from participants in prior national youth corps programs.

Apprenticeship Training

Persons completing apprenticeships as machinists and tool and die makers totaled less than 1,500 per year recently. Yet, an estimated 105,000 new career openings for machinists will become available between 1965 and 1975, and 45,000 openings will be available for tool and die makers. Some experts feel that apprenticeship is one of the best types of formal skills training conducted by industry. Yet, apprenticeship training supplies only a small proportion of the workers needed in skilled crafts. Since employers are the ultimate users of many of the skills for which training is made available, they should be in the best position to assess the skills needed by their workers. Without doubt, employers need to continue to have a major role in designing and supervising training in specific skills. One chief barrier to the expansion of formal training within industry is the large and increasing cost of such programs. Small firms may not be able to afford the cost of inplant training programs or be willing to take the risk of losing a substantial training investment if the trained workers leave to accept higher paying jobs. Programs need to be devised to provide incentives for employers to undertake such programs.

CREATING NEW JOB OPPORTUNITIES

Historically, technological development provided substitutes for human muscle power and mechanical skills. Electronic computers are providing, and will continue to provide mechanical substitutes for some human mental operations. As yet, no technology promises to duplicate human creativity, especially in the artistic sense, if only because we do not yet understand the conditions and functioning of

creativity. Mechanical equivalents for the emotional dimensions of man do not appear to be in the offing, either. For the forseeable future, distinctively human work will be less and less of the "muscle and elementary mental" kind and more and more of the "intellectual and artistic creativity and emotions" kind. This does not mean that only highly inventive or artistic people will be employable in the future. There is much sympathy needed in the world, for example. Many people who might not qualify for positions which require highly technical or intellectual skills, could be utilized in a variety of humanizing roles.

Consequently, activities need to be undertaken to plan for, to identify, and to bring about the acceptance of new job roles in which the skills and talents of disabled individuals may be usefully employed. Programs need to be designed and tested which provide individuals with job roles heretofore considered economically unfeasible, though socially desirable.

This issue involves a number of questions, such as the following:

- For whom are new jobs needed?
- What kinds of jobs can be created?
- Which types of jobs are appropriate for which population groups?
- Who are the potential employers?
- How are the costs of employment to be financed?
- How can such jobs be given status and community acceptance?

New jobs are needed for those who cannot find employment through the labor market either because the jobs do not exist or because they lack the skills for the jobs that do exist. There will be some residue of such people even if employment placement programs become more comprehensive and even if the labor market becomes tighter. Typically, the people found in this category are out-of-school youth with limited education, elderly persons, middleaged breadwinners displaced from regular jobs, and people with special physical, mental, or emotional handicaps.

One obvious area for new jobs is in the human service fields. Education, health, mental health, and social service agencies of all types are short of professional personnel and many agencies now use nonprofessionals in new types of positions. A long list can be compiled of different types of aides: teacher aides, hospital attendants, information and referral clerks in social agencies, community and neighborhood aides, homemakers, health visitors, recreation aides, and many more.

Although little has been done in the industrial and commercial fields, it is entirely possible that similar types of service and facilitating jobs might serve a useful purpose in such enterprises. Right now, New York City needs a large corps of people to instruct passengers how to use the new subway lines. While this is a temporary situation, large scale organizations of all types may have growing needs for personnel to provide informational services and to man extracurricular community projects.

A major distinction needs to be made between unskilled jobs which are entry points toward careers requiring increasing skills as one proceeds up the career ladder; and unskilled jobs which are long term occupations in themselves. Which purpose is to be served will depend upon the capacities and motivation of the employee and his potential. In general, the approach to youth employment is to view unskilled jobs as short term training opportunities, leading to the acquisition of greater skills.

Career aspects of new jobs may possibly be ranged on a continuum from completely unskilled to subprofessional, to intermediate professional, to full professional such as teachers aide, teacher assistant associate, and teacher. Such an array makes possible both career progression, through education and training and slotting in of people at terminal points that represent their potential. Older people and those with handicaps that limit their potential, would find their place in this scheme.

Potential employers are primarily governmental and nonprofit agencies, although there is some growing evidence of interest and potential in the private sector.

Financing is the most difficult issue of all. Many of the new jobs are available now, as for example, the great shortage of unskilled hospital personnel. However, many of the potential employers do not have the funds to employ personnel, although they need them. Others can and do employ personnel, but at such low compensation as to make it difficult to induce people to take jobs.

Subsidization of some kind is essential — either through direct government employment at adequate wage, or through governmental subsidy in one form or another to nonprofit organizations and private employers. Both types of financing are already taking place. Substantial expansion would seem to require increased federal financing. How much the state can do on its own is questionable. At a minimum, it can take measures to seek maximum effectiveness of available federally financed programs.

Questions of status and recognition probably depend on education of community and political leadership, size and stability of new job programs undertaken, adequacy of compensation, and the genuineness of the career opportunities provided.

New organizational structures could also be designed to further promote the creative exploration of new but individually and socially useful roles. Local community organizations with extensive representation from people living in the neighborhood, in cooperation with an area planning action council or an area service center, could be established to:

- Identify emerging local needs and develop programs for making communal life more humane and relevant to the general levels of affluence and production patterns possible.
- Provide a center for training and retraining of individuals for available occupations, developing occupations, and occupation creation experimentation.

Employment of the economically disabled in projects directed toward their own neighborhoods is already emphasized through Office of Economic Opportunity sponsored community action programs, perhaps the main arm of the war on poverty. Community action projects are underway in more than 1,000 cities and towns throughout the nation.

Economically disabled persons actively participate in the program as members of the governing board, as paid staff members, and as clients. Most significantly, employment of the economically disabled in projects directed to their own neighborhoods will involve more than 100,000 people employed as teacher aides, health aides, child supervisors or clerks. In many cases, specialized job training potentially allows for the development of careers outside of the antipoverty program.

Authorized by the Demonstration Cities and Metropolitan Development Act of 1966, the Model Cities program provides one mechanism for a new massive and coordinated approach to regenerating deteriorated neighborhoods which can also provide occupations for the disabled. Programs focus on specific target areas and attack deteriorating delapitated housing as well as the lack of such services as health, recreation, fire protection, education, sanitation and street repair.

A most significant potential within the Model Cities program is that the rehabilitation of dilapidated housing should offer increased employment of residents of the target areas. Thus, new jobs will be created to allow individuals to direct their energies in an economically productive way towards community improvement and betterment Where residents lack skills required for the jobs, programs may institute appropriate training with assistance from Labor Department sponsored work-training programs.

ADAPTING EDUCATION TO TECHNOLOGICAL CHANGE

The average young person entering the work force today will go through three or more work cycles of retraining or of new careers because of the new technologies and new intellectual techniques. Education for change, a new watchword, nevertheless validly points in the direction of the educational system. What appears to be needed is opportunity to upgrade skills and to allow for a changeover in careers and work patterns. This must be made available throughout the work life of all Americans.

Curriculum changes are necessary to systematically take into account the changes occurring in our society. Changes to particular subject matter areas appear most likely in the short run and entire curriculum design is probably necessary in the long run.

Consequently, activities need to be undertaken to develop concepts and programs concerned with life cycle education. People need to be able to return again and again for retraining or further education with the minimal loss of income whenever economic and social changes require a change in occupational skills and jobs. Demonstration programs to identify and to test core curricula which prepares individuals to effectively cope with changes in occupations and life styles resulting or likely to result from technological change are also a necessity.

THE ADVERTISING COUNCIL, INC.

Rehabilitation for The Mentally and Physically Disabled Campaign

30-SECOND RADIO SPOT #2

ANNOUNCER

Maybe you have a disability. And maybe you're giving it the best years of your life. It doesn't have to be that way. Today, with proper guidance and medical aid, you can be taught to take care of yourself. And learn a job you like. If you're disabled, or concerned about someone who is, write to this address. Write: HELP, H-E-L-P ... Box 1200, Washington, D.C. 20013. You've got nothing to lose but your disability.

EXPANDING REHABILITATION RESEARCH IN MASSACHUSETTS

RECOMMENDATIONS

EXPANDED REHABILITATION RESEARCH

150. To enhance rehabilitation research in the Commonwealth, and to stimulate the role of research in the formation of rehabilitation programs and policies, emphasis should be placed on:

- Developing an early interest in rehabilitation research among trainees in the social, biological and medical sciences.
- Enhancing communication between researchers and practitioners.
- Strengthening the research units of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind.

Training in Research

UNDERGRADUATE

151. To promote an early interest in rehabilitation research, courses in the concepts of disability and rehabilitation should be established in undergraduate curricula in the biological and social sciences as well as in liberal arts programs at selected colleges and universities.

GRADUATE

152. Graduate schools should establish advanced courses in concepts of disability, rehabilitation and in research methodology for students in the biological and social sciences, and in professional fields related to rehabilitation. Training programs currently financed by the Rehabilitation Services Administration in fields such as rehabilitation counseling, rehabilitation administration, and rehabilitation medicine should include courses in research methodology.

POSTGRADUATE

153. An interuniversity postdoctoral research training program in rehabilitation should be established where adequate facilities exist. The regional office of the Rehabilitation Services Administration should initiate exploration of this program by convening a group representing the colleges and universities conducting graduate training in rehabilitation.

CAREER FELLOWS

154. A program of career fellows in rehabilitation research, similar to established programs of the National Institutes of Health, should be initiated by the Rehabilitation Services Administration, to provide long term support to outstanding scholars for uninterrupted research.

RESEARCH SPECIALISTS

155. At least two institutions of higher learning should establish master's degree programs for training research specialists in the medical, social and biological sciences. These programs should emphasize statistical and experimental methodology as well as computer and other instrument skills. The Rehabilitation Service Administration should take responsibility for providing fellowships to students expressing an intention to work in areas of its responsibilities.

156. At least two institutions of higher learning should establish advanced training programs for workers in rehabilitation related fields who show promise for a career in research. The Rehabilitation Service Administration should consider providing special grants to receptive institutions to develop programs for these students.

RESEARCH TECHNICIANS

157. Programs to train research technicians should be developed at community and junior colleges. Primarily emphasis should be given to developing computational skills as they relate to research methodology and design.

CONTINUING EDUCATION

158. A program of continuing education which focuses on an introduction to research methodology and the understanding of research findings should be developed for individuals working in rehabilitation related service fields.

ROLE OF PROPOSED EDUCATION UNIT

159. The proposed communications and education unit of Massachusetts Rehabilitation Commission should aid institutions of higher education in developing undergraduate and graduate courses in rehabilitation and assist these schools in applying for training funds from the Rehabilitation Services Administration. This Unit should also be responsible for developing continuing educational programs for individuals working in rehabilitation related fields.

Facilitating Research Communication

INTERUNIVERSITY REHABILITATION COMMITTEE

160. To promote continuing interchange among university scholars involved in rehabilitation research, an interuniversity rehabilitation committee should be established under the auspices of the Regional Rehabilitation Research Institute, Northeastern University. Among other activities, this committee should investigate methods for promoting regularly scheduled conferences on rehabilitation research.

A NEW JOURNAL

161. A professional advisory board of outstanding research scholars in rehabilitation should be convened under the auspices of an interested university in the Commonwealth to explore the establishment of a *Journal of Rehabilitation Research*, as no present publication deals exclusively with research in this field. The Massachusetts Rehabilitation Commission should assist in exploring sources for financing this Journal.

RESEARCH CONSULTATION TO SERVICE AGENCIES

162. The Regional Rehabilitation Institute, Northeastern University, should provide research consultation to agencies interested in doing research but lacking sufficient research experience. The Rehabilitation Services Administration should provide funds to the Regional Rehabilitation Institute for these consultation services.

Research Activities of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind

RESEARCH AT THE MASSACHUSETTS REHABILITATION COMMISSION

163. The present Research and Program Planning Unit of the Massachusetts Rehabilitation Commission should be reorganized as Research and Planning Units headed by Directors of Research and Planning responsible to the Assistant Commissioner for Planning, Training, Research, and Education. This section should process and evaluate grants; consult with outside agencies with respect to their research needs; and direct operational and evaluative research.

164. A permanent position of director of research should be established at the Massachusetts Rehabilitation Commission. Additional professional staff positions should be provided in order for the Research Section to meet its increased responsibilities.

RESEARCH AT THE MASSACHUSETTS COMMISSION FOR THE BLIND

165. A permanent position of supervisor of research should be established at the Massachusetts Commission for the Blind. The administrator should supervise rehabilitation research and should be responsible to the proposed director of planning, training and research.

COORDINATION

166. A coordinated program of rehabilitation research should be jointly established between the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind.

JOINT RESEARCH ADVISORY COMMITTEE

167. The Commissioner of Rehabilitation and the Commissioner for the Blind should appoint a joint research advisory committee composed of senior researchers and rehabilitation administrators to provide advice on the future role and direction of public rehabilitation research programs.

FOCUS OF INTEREST

What should rehabilitation research concern itself with? Which problems should receive the greatest attention? Which problems have been most neglected? Which problems require a sharper focus?

Answers to these questions primarily involve the adequate training of research personnel, the development of better means for communication and coordination between researchers, the provision of maximum incentives and supports for researchers and the strengthening of the research sections of the public rehabilitation agencies.

A great variety of rehabilitation related research is presently being conducted, such as:

- Studies of nursing home rehabilitation services by Northeastern University's Regional Rehabilitation Research Institute.
- The efficacy of camping programs for handicapped children integrated with non handicapped children by the Easter Seal Society.
- Workshop need surveys at the Greenfield office of the Massachusetts Rehabilitation Commission.
- Investigation of a multidisciplinary training program in drug addiction at the Drug Addiction Unit of Boston State Hospital.
- The development of techniques in the rehabilitation of hardcore unemployed clients by the Massachusetts Department of Welfare and the Massachusetts Rehabilitation Commission.
- Investigation of prosthetic devices by Massachusetts General Hospital.
- Hospital Improvement Projects at facilities of the Department of Mental Health investigating the rehabilitation of mentally ill and retarded residents.

The longrange direction and the development of priorities among content areas for investigation, however, represents a far more serious question. Indeed, it is suggested that the issue of the most appropriate subject matter for the field to pursue is of lesser concern than the three issues described above. Federal and state agencies most directly responsible for financing research in rehabilitation are in a transitional period regarding their mandates. Therefore, the research system should be flexible enough to respond quickly and easily to future changes in needs and demands.

In addition, the field of rehabilitation is as broad as the imagination and creativity of the administrative, case service and research personnel involved in the field. Thus, no single set of areas for investigation can reasonably guide the researcher. Furthermore, the breadth of the field clearly suggests that research can be supported by many federal and state agencies as well as by private foundations. For all these reasons, the question of what problems to investigate are best left to the multiple influences of political and social demands and the interests of the investigators themselves. Instead, this section concentrates upon:

- Developing adequately trained researchers and technical personnel.
- Facilitating communication among researchers and between researchers and practitioners in relevant service fields.
- Strengthening the research units of the public vocational rehabilitation agencies within the Commonwealth.

TRAINING IN RESEARCH

At present, conflict exists between two approaches to developing rehabilitation research specialists. One approach views rehabilitation research as a discipline requiring special training, perhaps special methodology. Disability and restoration receive emphasis without a more generic discipline such as psychology, medicine or sociology as a base.

A second approach envisions research training in a particular discipline, with secondary interest in the rehabilitation process. Emphasis would remain on training scientists and technical personnel in the medical, biological and social sciences, and in the service professions primarily involved in rehabilitation such as physical therapy, occupational therapy and speech and hearing therapy. Students would be exposed to rehabilitation concepts early in training and receive regular exposure throughout continued studies. This approach has the distinct advantage of developing a solid content providing a broader context in which the rehabilitation process can be creatively viewed. Therefore, the second approach is generally felt to be the preferred course of action. University programs and agencies providing rehabilitation services are the two primary sources for recruiting research personnel. Only through early and continued exposure to research can students acquire sufficient experience to appropriately reach a vocational decision.

Undergraduate Training

A first step towards promoting interest in rehabilitation research can be taken by having undergraduate curricula, within the biological and social sciences in particular, and in liberal arts programs in general, include a course in the concepts of disability and rehabilitation. Initially, a course might be developed at selected colleges and universities in Massachusetts which already have well developed specialty programs in some phase of rehabilitation such as Boston University, Northeastern University, Tufts University, Springfield College or Clark University. Appropriate departments of these schools could apply to the federal Rehabilitation Services Administration for demonstration funds to evaluate whether the new courses increase the numbers of students who go on to careers in rehabilitation related fields.

Graduate Training

At the graduate level, exposure to rehabilitation should be continued. If students become more deeply involved in

research while in graduate schools, the possibility of developing a rehabilitation career goal will be improved. During graduate school, students can benefit from involvement with faculty members' ongoing research, experience interdisciplinary interaction, and participation in joint symposia on rehabilitation research. Graduate programs in the biological and social sciences and professional programs such as medecine, nursing, dentistry and others related to rehabilitation, should be encouraged to include more advanced courses in concepts of disability and rehabilitation. Again, it seems appropriate to select schools already involved in rehabilitation programs and to suggest application to the Rehabilitation Services Administration for demonstration funding.

Training programs are currently financed by the Rehabilitation Services Administration in such fields as rehabilitation psychology, rehabilitation counseling and rehabilitation social work in institutions such as Boston University, Assumption College (Worcester, Massachusetts) and Pennsylvania University. These training programs should include concepts in research methodology which might open the path to potential researchers already interested in the rehabilitation field. In addition, the courses could improve the potential for future dialogue between service professionals and research workers.

Postgraduate Training

When a student's training in a generic field is complete and his interest in rehabilitation has been fostered, a system of advanced and highly specialized study for a select group of scholars committed to research in rehabilitation becomes particularly important. Towards this end, one postdoctoral training program in rehabilitation should be established in the Commonwealth with adequate facilities and with a new type of administrative structure — an interuniversity training program. A number of highly active academic and professional programs of rehabilitation training already exist in the Boston area. Exposing research specialists to the broad spectrum of programs existing at the Tufts University Research and Service Center, the Northeastern University Administrative and Research Training Program and the activities of the Boston University Rehabilitation Council would provide a unique educational experience, particularly if these schools attempt to develop an integrated curriculum. An advisory board, representing these institutions, should explore the development of such a postdoctoral, interuniversity program.

Career Fellows

An additional problem relates to the support of investigators of outstanding promise allowing long term programs to be carried out without the continual pressure of a renewal of soft money grants. A rewarding solution would utilize the experience of the National Institutes of Health if the federal Social and Rehabilitation Service initiated a program of career fellows in rehabilitation research. Outstanding scholars would receive long term financial support directly through the Social and Rehabilitation Service or the Rehabilitation Services Administration, relieving them of the nonresearch responsibilities required in the academic environment. Career fellows would be free to choose and to change the site of their research, the content and, indeed, the basic direction. Hopefully, career fellows would become the elite cadre for initiating new and creative directions for the rehabilitation field.

Research Specialists

A significant shortage of middle level technical personnel equipped to handle the responsibilities of research assistants on major projects also exists. A questionnaire survey of 125 rehabilitation researchers within the Commonwealth was conducted by the Vocational Rehabilitation Planning Commission and reinforced the awareness of the lack of trained specialists. Specialists are needed with a master's degree level of training. However, this shortage is felt not only within the rehabilitation area but throughout the social and biological sciences. For this reason, master's degree programs should be developed at selected colleges and universities for training technical research specialists in all areas of the medical, social and biological sciences. Programs should emphasize statistical and experimental methodology as well as computer and other instrument skills.

Another , and largely untapped, resource for recruitment of potential contributors to research is made up of case service personnel currently engaged in the rehabilitation field. Often, the experience gained through providing direct services can be the most meaningful catalyst for significant research questions. However, the initiator of the questions is frustrated in his desire to answer them because of his lack of technical training in research methodology. Case service personnel who show an appitude and interest in research may be the best motivated of all potential candidates for career development. These individuals, in particular, should be encouraged to pursue their interests.

To meet the needs for these rehabilitation service personnel, two year, nondegree research fellowship programs should be established at selected academic centers in Massachusetts. The federal Rehabilitation Services Administration should consider providing grants to receptive institutions desiring to initiate a program on a pilot demonstration basis. In addition to direct stipends, the Rehabilitation Services Administration should explore the feasibility of using existing state and federal training funds, as well as encouraging use of paid leaves of absence for training purposes.

Research Technicians

Personnel shortages which presently exist in all areas of research include research technicians with post high school training in computational and bookeeping skills. Research technicians could handle a large amount of the clerical type work so frequently required in research in any field. Too

often the clerical work is performed by individuals with far more training and experience than the task requires. Health and welfare fields abound with examples of highly trained personnel fulfilling responsibilities which could be just as well or better performed by persons with less training. Selected junior and community colleges in the Commonwealth should develop a program to train research technicians emphasizing computation skills as they relate to research methodology and design.

Continuing Education

Even if all these research training recommendations were implemented, the problem of communicating the results of research from the researcher to the practitioner would still exist. Without a minimal knowledge of research methodology, individuals often manifest resistance to research findings and their application. As a result, a program of continuing education should be developed for individuals working in rehabilitation related service fields. At least one such program should include an introduction to research methodology and the understanding of research findings. Periodic meetings and conferences around the state should be developed as the primary vehicle for implementing this educational enrichment.

Role of the Massachusetts Rehabilitation Commission's Proposed Communications and Education Unit

The proposed Communications and Education Unit of the Massachusetts Rehabilitation Commission should develop a continuing education program in collaboration with the Research Unit of the Massachusetts Rehabilitation Commission. In addition, the Unit should also aid institutions of higher education in developing undergraduate and graduate courses in rehabilitation and assist these schools in applying for training funds from the Rehabilitation Services Administration.

FACILITATING COMMUNICATION REGARDING REHABILITATION RESEARCH

Interuniversity Communication

An essential step towards insuring maximum utilization of ongoing research is to motivate persons engaged in research to communicate with each other This concept is particularly relevant for the academic institutions which are at present the primary locus of research activities. Toward this end, an interuniversity rehabilitation committee should be established to promote the necessary interchange between academic institutions. The committee should explore techniques for informing the schools about ongoing research, while noting progress and difficulties, encourage the exchange of students and/or faculty in experimenting with academic innovation and sponsor joint colloquia and seminars. The Regional Rehabilitation Research Institute at Northeastern University would be the most appropriate agency to coordinate the interuniversity rehabilitation committee. The Institute should consider the feasibility of applying to the Rehabilitation Services Administration for funds to administer an ongoing committee.

Rehabilitation Research Conferences

Regional meetings of rehabilitation researchers should be held to promote further interchange among professionals. A meeting devoted xclusively to rehabilitation research was recently held at the initiation of the Research and Demonstration Task Force of the Vocational Rehabilitation Planning Commission. Furthermore, the regional office of the Rehabilitation Services Administration is presently involved in planning regional rehabilitation research meetings. Regional meetings, devoted to the dissemination of significant research findings and their implications should be established on a regular basis. In addition, meetings should be organized which v ill be useful to participants at many levels of experience, from the researchers with a long history of involvement in the field through the undergraduate neophyte. Programs should include a number of topics at various levels of complexity. Methods for initiating such conferences should be a major responsibility of the proposed interuniversity rehabilitation committee under the auspices of the Regional Rehabilitation Research Institute at Northeastern University.

New Journal

The question of establishing a journal specifically devoted to rehabilitation research has often provoked great controversy. Some professionals believe that a glut of journals already exist on the market and to add another would just increase the burden of trying to keep up with relevant developments in the field. Others feel that the heterogeneity of the content of rehabilitation research makes it more appropriate for articles to appear in many types of journals. Nevertheless, it is felt that cohesiveness and unity can be achieved only when rehabilitation research reaches the stage of maturity that demands its own vehicle of communication. Scattering relevant research among various publications acts as a severe deterrent to professional identification and to allowing researchers or potential researchers the opportunity to absorb a sense of the total content of their field. For these reasons, a professional journal of rehabilitation research is necessary.

The journal should be multidisciplinary in scope and should appeal to a national audience. An integral part of the journal should be an abstracting service of equal professionalism. In addition, the journal could make a unique contribution to bridging the gap between researchers and practi-

tioners by providing a periodic supplement with less technical summaries of articles, noting the implications for practical application. This supplement should be directed primarily to the service worker and would have a far greater potential circulation than the regular issues. Towards these ends, a professional advisory board made up of outstanding rehabilitation researchers should be convened under the initial auspices of an interested academic institution. The Massachusetts Rehabilitation Commission should assist this institution in exploring sources for financing the journal.

Consultation to Service Agencies

Service agencies themselves can be considered as sources for the development of new ideas and for the focus of action research and demonstration projects. Too often, agencies are limited in personnel and cannot afford to send staff for advanced training. To make maximum use of this service agency resource, the Regional Research Rehabilitation Institute at Northeastern University should make research consultation available to agencies expressing an interest in research but lacking sufficient experience to maintain full autonomy of projects. The Institute should consider applying to the Rehabilitation Services Administration for additional funds to promote this consultative role.

RESEARCH AT THE MASSACHUSETTS REHABILITATION COMMISSION

Presently, the Research and Program Planning Unit of the Massachusetts Rehabilitation Commission is responsible for:

- Processing research grant requests made to the federal Rehabilitation Services Administration by individuals or agencies in Massachusetts.
- Conducting operations research required by the Massachusetts Rehabilitation Commission itself.
- Consulting with agencies and individuals desiring help in developing research proposals.
- Conducting its own research and demonstration projects related to significant problems in rehabilitation.

To accomplish these complex and manifold tasks, the unit is presently staffed by a director and four research assistants. While performing quite different tasks, the research assistants all are in the same civil service category, the only one available to the Commission. The director's position is a temporary one. Even the existing responsibilities cannot possibly be adequately met by such a small staff with only two levels of positions.

Separate Research Unit

To meet the present responsibilities as well as those recommended later, the Research and Program Planning Unit of the Massachusetts Rehabilitation Commission should be reorganized into separate research and planning units. The position of Director of Research should become a permanent civil service position. The Directors of Research and Planning should be directly responsible to the Assistant Commissioner for Planning, Training, Research and Education.

Additional Responsibilities for the Research Unit

Two public agencies in the Commonwealth are responsible for providing direct rehabilitation services to the disabled (the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind) and a federal agency has a similar mandate at the national level (the Rehabilitation Services Administration of the Social and Rehabilitation Service). Clearly rehabilitation research, covering the broad spectrum of disabled and disadvantaged members of our society, crosses agency boundaries. As a result, all major disciplines engaged in rehabilitation research, as well as major departments and organizations servicing the public in Massachusetts, such as the Departments of Mental Health, Public Health, Public Welfare, Public Safety and the Commonwealth Service Corps, are concerned with the flow of research information.

Because of this complex mix, it is particularly important to maintain a system for:

- Keeping track of rehabilitation research and demonstration projects being conducted under various auspices in the state.
- Maintaining a central registry of all individuals in Massachusetts engaged in rehabilitation research including their affiliation, the areas being investigated, and the source of funds.
- Maintaining up-to-date information of federal-state regulations, granting procedures, and programs which may be significant to investigators in the Commonwealth.

Because of its central position in rehabilitation research and its potential for communicating with other departments of the state and federal government as well as with private and public agencies in Massachusetts, the Research Unit of the Massachusetts Rehabilitation Commission should take responsibility for developing this major new function of disseminating information.

Functional Organization of the Unit

With its many heterogeneous responsibilities, the proposed Research Unit should be organized on a functional basis. Grant processing, operational and evaluative research, research consultation, conducting special research projects, disseminating information regarding research programs, state-federal communication, and maintaining a central research registry should be organized into a number of discrete activities within the proposed research unit of the Massachusetts Rehabilitation Commission. Adequate staff should be provided for the unit to accomplish its manifold tasks.

In addition to the Research Director, a minimum of two research associates (civil service grade 19) two research assistants (civil service grade 17); three research technicians (civil service grade 13) and three research clerks (civil service grade 10) will be necessary to staff the Unit.

RESEARCH AT THE MASSACHUSETTS COMMISSION FOR THE BLIND

Massachusetts is one of several states in which a separate agency exists to service the blind. While the agency is smaller, and its responsibilities are restricted to a single disability group, all of the organizational requirements stressed for the Massachusetts Rehabilitation Commission are equally valid for the Massachusetts Commission for the Blind. The Commissioner for the Blind should request a full time supervisor of research whose functions would be comparable to those indicated for the research director of the Massachusetts Rehabilitation Commission. Close professional collaboration should be established between the supervisor of research of the Massachusetts Commission for the Blind and the Director of Research of the Massachusetts Rehabilitation Commission, as well as with all public and private agencies involved in serving blind persons.

COORDINATION AND THE JOINT RESEARCH ADVISORY COMMITTEE

Maximum productivity between the research units of the two rehabilitation agencies can best be achieved through a broadly based, long term research planning effort, based upon a coordinated program of rehabilitation research jointly established between the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind. Towards this end, the Commissioner of Rehabilitation and the Commissioner for the Blind should appoint a joint research advisory committee composed of senior researchers and rehabilitation administrators to provide advice on the future role and directions of public rehabilitation research programs.

If the recommendations suggested in this section can begin to be implemented, vigorous and expanded research can be realized in rehabilitation within the Commonwealth.

DEVELOPING MANPOWER TO PROVIDE REHABILITATION SERVICES

RECOMMENDATIONS

Increased Manpower Needs

INCREASING PERSONNEL

168. To meet greatly expanding responsibilities and with anticipated increases in federal allocations, professional and clerical personnel at the Massachusetts Rehabilitation Commission should be increased four-fold, from about 400 to 1600 by fiscal year 1976.

169. To meet expanding responsibilities and with anticipated increases in federal allocations, professional and clerical personnel at the Massachusetts Commission for the Blind should be increased from about 200 to 300 by fiscal year 1976.

New Positions and Pay Classifications

NEW PAY GRADE CLASSIFICATIONS

170. A three level position and pay grade classification structure should be established for rehabilitation counselors at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to reflect differences in experience, educational background and responsibilities.

To implement the above recommendation the following personnel and pay grade classifications are recommended at salary levels which are competitive with other public and private rehabilitation agencies.

Title	*Pay Grade*
Rehabilitation Counselor I	15
Rehabilitation Counselor II	17
Rehabilitation Counselor III	19

171. A three level position and pay grade classification structure should be established for social workers at the Massachusetts Commission for the Blind to reflect differences in experience, educational background and responsibilities.

To implement the above recommendation, the following personnel and pay grade classifications are recommended at salary levels which are competitive with other public and private rehabilitation agencies.

Title	*Pay Grade*
Social Worker I	15
Social Worker II	17
Social Worker III	19

DIRECT CLIENT WORK AS A CAREER

172. A civil service position for rehabilitation counselor III or social worker III should be established for professional staff who wish to work directly with clients during their entire career.

VARYING ENTRY LEVELS

173. Civil service regulations should be changed to permit the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to hire counselors and social workers at varying entry levels based on educational background and experience.

EDUCATIONAL REQUIREMENTS

174. In the future, all persons hired by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind as Rehabilitation Counselors I, II and III should have at least a masters degree from an accredited counselor training program or in a rehabilitation related field.

Training and Upgrading Public Agency Personnel

BROADENING THE TRAINING

175. The training and upgrading of personnel should receive increased emphasis among all public agencies rendering rehabilitation services.

At least 10% of the annual personnel budgets of public agencies rendering rehabilitation services should be allocated for inservice training, educational leaves, student scholarships and internships and for training programs for supportive personnel.

Interagency training programs should be conducted whenever feasible as determined by the proposed state Rehabilitation Coordinating Council.

EDUCATIONAL LEAVES

176. To give public agency personnel the opportunity to increase their professional skills, educational leaves with pay should be granted annually to at least two per cent of the full time staff of the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and the Departments of Mental Health, Public Health, Public Welfare, Education and Correction. The Division of Youth Service, the Division of Employment Security, the Parole Board and the Commissioners of Probation.

Step increases, promotion eligibility and fringe benefits should be ensured for employees while on educational leave.

177. Consideration should be given to expanding leave time to one year at full pay and two years at half pay to allow personnel to complete graduate degrees within a reasonable time.

SUMMER INTERNSHIP PROGRAM

178. At least 500 summer internship positions should be developed and financed by the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Department of Mental Health, Public Health, Public Welfare and Correction and the Division of Youth Service to acquaint students with different opportunities in the field of rehabilitation.

TRAINING PROGRAMS FOR SUPPORTIVE PERSONNEL

179. A one year training program for rehabilitation and social work trainees should be established by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind for persons who do not meet the educational requirements for professional personnel at these agencies.

Trainees should learn skills which will enable them to assist professional personnel in administrative and direct client work under appropriate supervision.

Trainee positions should be limited to one year and should not be part of the classified civil service.

REHABILITATION AND SOCIAL WORK ASSASTANTS

180. Persons who successfully complete the proposed one year program for rehabilitation or social work trainees should be accepted for employment as rehabilitation or social work assistants.

Special university based training programs should be developed providing equivalent training on a masters degree level to offer rehabilitation or social work assistants the opportunity to qualify for appointment as rehabilitation counselors or as social workers.

DIRECTORS OF TRAINING AND RECRUITMENT

181. Full time positions of Director of Training and Recruitment should be established at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind.

The present training staff at each agency should be expanded so that appropriate training programs may be conducted regularly on all staff levels and to expand recruiting activities.

COUNSELOR SUPERVISION

182. All professional staff at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should receive regular professional supervision of their caseload.

Curricula and Course Development

EMPHASIS ON THE TEAM APPROACH

183. Colleges and universities conducting training in rehabilitation related fields should acquaint their students with the contributions of related professions to prepare them to function on inter-professional teams.

INTERDISCIPLINARY REHABILITATION TRAINING CENTERS

184. New training programs should be developed to provide an interdisciplinary rehabilitation work experience for students of professional schools and for workers from rehabilitation related fields.

At least two of the proposed area disability evaluation centers, one in the eastern and one in the western part of Massachusetts, should be designated for this special training function.

JUNIOR COLLEGE PROGRAMS TO TRAIN SUPPORTIVE PERSONNEL

185. Junior and community colleges should develop programs to train supportive personnel for the various rehabilitation related professions such as physical therapy, rehabilitation counseling special education, occupational therapy, nursing and social work.

Agency administrators and professionals rendering direct client services and professional associations should be actively consulted in the formulation of the curricula.

EXPANDED CLERICAL STAFF

186. One senior clerk typist or one senior clerk stenographer should be budgeted for every two counselors at area offices of the Massachusetts Rehabilitation Commission and offices of the Massachusetts Commission for the Blind to provide adequate clerical help and assistance to counselors.

AUTHORITY TO HIRE

187. Legislation should be passed giving state agency administrators the authority to hire appropriate personnel directly to fill existing vacancies pending final approval by the Bureau of Personnel and Standardization.

MODIFICATION OF VETERAN'S PREFERENCE

188. Massachusetts civil service laws should be amended to eliminate absolute veteran's preference and to adopt the federal system which provides disabled vererans with a ten point preference and other veterans with a five point preference over their attained grade in competitive civil service examinations.

MORE MANPOWER NEEDED

Current manpower shortages show no promise of significant improvement. Physicians, occupational therapists, psychiatrists, psychologists, school teachers, guidance counselors, rehabilitation nurses, rehabilitation counselors, social workers, speech and hearing therapists and other professions, all vital to the rehabilitation of disabled persons are suffering manpower shortages. In addition, ineffective use is often made of available manpower. Therefore, the crucial question remains of how best to utilize scarce and increasingly costly professional and technical manpower to serve the greatest number of individuals with high quality rehabilitation programs.

Broadening the rehabilitation concept to serve all types of physical, mental and social disabilities will cause continued expansion of rehabilitation facilities and programs to serve more people with increasingly complex problems. Vastly increased numbers of workers at all levels of education and training will be required.

Generally, there is agreement that the major reasons for the manpower shortage in the rehabilitation field can be attributed to the following:

- Increasing demand for rehabilitation services on all levels.
- Limited capacity of professional schools.
- Lack of concensus about the role and status of persons with incomplete professional training.
- Inefficiency in the delivery of professional services, particularly in the use of the professional's time.
- Inability to recruit professionals in sufficient numbers.

Basic to the shortage is the fact that there is only a limited pool of people for whom all professionals are competing. This basic pool of rehabilitation workers can be enlarged by dealing with the status of the rehabilitation professions and by raising the economic and professional rewards for workers at all levels.

TRAINING AND RECRUITMENT IN RURAL AREAS

Success in attracting personnel may be directly related to the geographic location of facilities. Facilities located far from population centers are professionally, culturally and socially isolated and have difficulty in attracting experienced professionals. Young professionals may work in outlying areas only until job openings become available in Boston or other cities. As a consequence, the rural areas experience a high degree of manpower turnover. Attempts to attract personnel to remote areas have included loan forgiveness programs and salary differentials but with little success. Traveling clinics and television clinic hookups with rural hospitals and rehabilitation facilities are means which should be expanded to provide professional consultation and staff development in rural areas.

The particularly acute shortage of rehabilitation personnel outside of Boston and other major population centers in Massachusetts appears to be closely related to the absence of training facilities outside the major cities.

When training resources are not actually located near rural areas an effort should be made by schools which train rehabilitation workers to affiliate with rural hospitals to increase the supply of professionals available there and to acquaint personnel with work in rural areas. This arrangement is used by the Berkshire and Worcester Rehabilitation Centers, which provide services for hospitals and nursing homes in their areas.

REHABILITATION COUNSELING

Special consideration should be given to the status of rehabilitation counselors, one of the newest and a key profession in the rehabilitation process. Rehabilitation counselors are carrying out major functions and responsibilities which have been traditionally been those of other professions. Placement of clients from schools for the retarded and state hospitals has traditionally been a function of social workers. Sometimes there is an overlap of responsibilities with psychologists in the testing of clients and in counseling and with social workers in respect to casework services.

The unique professional contribution of the rehabilitation counselor lies in his knowledge about the world of work, in his ability to coordinate rehabilitation plans and in helping the client towards vocational adjustment. To use these skills effectively, the counselor requires certain psychological tools which are, at times, seen by other professionals as infringements on their professional functions. Part of the obstacle in defining the rehabilitation counselor's function more precisely rests in the counselor's preference to perform certain tasks. In what should be a unified process in the client services of vocational evaluation, vocational training, placement and followup, there is often a tendency towards fragmentation because counselors may select to do evaluation and therapy in preference to placement and followup.

Administrators and policy makers need to be educated regarding the role that rehabilitation counselors can play in various settings. Many rehabilitation counselors fill positions which have not been created for them, such as mental health coordinator and education supervisor. Specific positions for rehabilitation counselors should be established by those departments providing rehabilitation services in keeping with the emergence of rehabilitation counseling as a profession.

Colleges and universities in Massachusetts graduated more than 300 students in 1967 in professions related to rehabilitation such as rehabilitation counseling, rehabilitation nursing, physical therapy, occupational therapy, speech and hearing and social work.

Graduate programs in most schools are being rapidly expanded to accommodate larger student enrollments. A brief description of training facilities in Massachusetts may be found at the conclusion of this section.

INCREASING PERSONNEL AT THE MASSACHUSETTS REHABILITATION COMMISSION

A new approach to vocational rehabilitation is burgeoning in the Commonwealth in which the Massachusetts Rehabilitation Commission must play a central role. Stimulus to move in the direction of assuming new and additional roles comes from within the Massachusetts Rehabilitation Commission and also from the initiative of the federal programs which emphasize a broader commitment for services to handicapped people. Services will be decentralized in geographic areas to improve local accessibility and broaden the range of services available in all parts of the Commonwealth. This will require an office of the Massachusetts Rehabilitation Commission in every area, usually with greatly expanded personnel.

The size of the responsibility and the expanded functions to be accomplished by the federal program through its state vocational rehabilitation agencies requires the Massachusetts Rehabilitation Commission and Commission for the Blind to expand staff to fill specific new roles, particularly with the emphasis on a delivery of services at the local level.

With the establishment of disability evaluation centers and the expanded vocational rehabilitation responsibilities of the mental health-retardation centers, new job roles must be created for counselors as members of the professional team conducting vocational evaluations. The role of liaison staff would also require them to assume responsibility to act as coordinator and expediter for clients in their area. Regardless of the referral sources, the liaison counselor would be required to assume responsibility for the flow of information and services to the client through public and private resources, to formulate decisions in consultation with other team members, to coordinate plans with representatives from other agencies, and to function as the constant professional person in the client's life.

Counselors from the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should also provide liaison and consultation to local public and private schools, general hospitals, courts, correctional

institutions, and other alerting stations to assist in early case finding and in the referral of clients to appropriate agencies.

Three major factors necessitate a dramatic increase in the personnel of the Massachusetts Rehabilitation Commission. First are proposals for improved casefinding and faster and better vocational services on the local level. Second, it must be emphasized that these recommendations do not only apply to the present caseload of the Massachusetts Rehabilitation Commission or to a gradually growing number of persons. The 1965 and 1968 amendments to the Vocational Rehabilitation Act greatly expanded the categories of clients for whom services may be funded under federal-state matching funds. These include evaluations and services for alcoholics, drug addicts and public offenders among others and vocational evaluations for socially disadvantaged persons. The latter opens a new type of commitment for an as yet unknown number of persons, requiring new methods and new roles for professionals and for aides. Last is the problem of "catching up." There is a wide discrepancy between the number of persons to whom the Commonwealth has been able to render vocational services and those who require such help. In 1967, the Massachusetts Rehabilitation Commission rehabilitated about 2,170 persons. Five times as many received evaluations and related services. But the task is so staggering that a 20-fold increase in the number of persons being served annually may be considered a conservative goal until the large backlog of individuals who are presently not working are evaluated.

A four-fold increase in personnel at the Massachusetts Rehabilitation Commission, from about 400 to 1600 over the next eight years will make sufficient inroads in alleviating the situation. This projected personnel increase is related to anticipated increased federal matching funds rising to $40 million by 1976 and to the recruiting potential of the Massachusetts Rehabilitation Commission.

INCREASING PERSONNEL AT THE MASSACHUSETTS COMMISSION FOR THE BLIND

Increases in personnel are needed at the Massachusetts Commission for the Blind in professional categories of rehabilitation counselors, social workers and home teachers and in nonprofessional categories such as fiscal accountants, supportive staff and clerical staff, with proportionate increases among supervisory and administrative staff.

Rehabilitation Counselors

Rehabilitation counselors fulfill traditional as well as unique functions in serving blind clients. Traditional responsibilities include providing vocational evaluations, training and counseling focused primarily on enhancing client skills for job placement. Counselors train clients directly in the management of vending stands. They refer clients to other training services which are purchased by the Commission.

The present 12 rehabilitation counselors should be doubled to provide rehabilitation services to a greater number of clients, particularly difficult cases, who require intensive work over a longer period of time

At least seven rehabilitation counselors III will be required to work directly with blind clients in their homes, particularly if required services are not available in the areas in which they live.

Clerical and Supportive Staff

Functions of clerical and supportive staff at the Massachusetts Commission for the Blind encompass a number of tasks in addition to the more common clerical duties such as traveling with clients, taking case notes, compiling control and statistical data and fiscal responsibilities. Because of these broader functions and the skills required to perform them, these staff members are considered to be clerical and supportive personnel. They are needed on a one to one ratio with professional staff, rather than the two to one ratio recommended for clerical staff at the Massachusetts Rehabilitation Commission. Presently the Commission for the Blind has 7 openings in the clerical and supportive job category.

As area offices of the Massachusetts Rehabilitation Commission are established in each of the geographic service areas, one clerical-supportive staff person from the Massachusetts Commission for the Blind should be assigned to every two areas to respond to telephone inquiries, to act as an immediate contact on behalf of the Commission and to refer clients to the rehabilitation counselors assigned to that area.

Social Caseworkers

Ten additional caseworkers will be needed to bring the total to 40 caseworkers. About half of these should work in intake and the service unit to help prepare clients for rehabilitation. The rest should be senior social workers, who are qualified to take care of intensive family problems and to work with multiple handicapped clients.

Home Teachers

In order that a proper balance of personnel be assured among the interdisciplinary members of the rehabilitation team, the staff of home teachers for the blind should be increased by at least five additional teachers.

Fiscal Services

Ten additional fiscal and accounting positions are required permanently to enable the Commission to identify client and financial data at any given time. This is presently not possible. Fiscal and client data are being converted to electronic data processing.

Supervisors and Administrators

About ten additional supervisors and administrators will be required to work with the expanded staff recommended above, based on an approximate ten to one ratio of supervisors and administrators to professional, clerical and supportive staff. Also to be included are the recommended positions of four assistant commissioners and one deputy commissioner discussed in the section on administration.

NEW POSITIONS AND PAY CLASSIFICATIONS

Current classification structures for rehabilitation counselors and social workers at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind are inappropriate to meet the current responsibilities of the agencies or the expanding responsibilities in providing comprehensive vocational rehabilitation services to handicapped citizens in the Commonwealth.

A three level classification is needed for rehabilitation counselors and for social workers to reflect differences in the background and responsibilities of personnel and to improve retention of personnel. This reorganization incorporates a general increase in salary raising all personnel by two pay grades. Additionally it also provides the opportunity for personnel to be hired at three entry levels based on background and experience rather than at the lowest professional level for a new worker as is presently the case. Such a change should greatly improve recruitment.

RECLASSIFICATION OF REHABILITATION COUNSELORS

Changes in Position Titles

To more accurately reflect professional functions, all the positions at the Massachusetts Rehabilitation Commission carrying the job title of "Supervisor in Education" should be retitled, "Rehabilitation Counselor." The present title creates ambiguity in working with other agencies and confuses the general public. These titles are a historical carryover from the time that the Massachusetts Rehabilitation Commission was a part of the Department of Education.

Categories of rehabilitation counselor I, II and III should be established at salary grades 15, 17, and 19 respectively.

The position of rehabilitation counselor is presently established at the Massachusetts Commission for the Blind at grade 13. This position should be raised to grade 15.

The positions of supervisor in education (grade 15) and senior supervisor in education (grade 17) should be reclassified as rehabilitation counselor II and III at pay grade 17 and 19 respectively.

Competitive Salaries

Beginning salaries for professional rehabilitation counselors at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should be competitive with salaries paid by other state rehabilitation agencies. A review of a survey compiled by the Rehabilitation Services Administration and the National Rehabilitation Counseling Association in 1968 indicates that the entry salary in Massachusetts is below that of 32 other states.

When differences in maximum salaries for counselors are compared, the Massachusetts Rehabilitation Commission is also at a distinct disadvantage. A counselor remaining in his job in Massachusetts can expect to receive a maximum salary of $8,683. Average top salary for counselors in the other 49 states is $10,101.

The situation with respect to social workers of the Massachusetts Commission for the Blind is even more serious. All social workers are presently classified as Senior Worker with the Blind at a pay grade of 11 ($5,935.80-$7,527.00). Three categories of social workers should be established at the Massachusetts Commission for the Blind at pay grades 15, 17 and 19.

To attract and retain qualified personnel, the following salaries are recommended for the staff of the Massachusett Rehabilitation Commission and the Massachusetts Commission for the Blind:

Title			*Pay Grade*
Rehabilitation Counselor I	**or**	**Social Worker I**	**15 ($ 7,938-10,028)**
Rehabilitation Counselor II	**or**	**Social Worker II**	**17 ($ 9,110-11,497)**
Rehabilitation Counselor III	**or**	**Social Worker III**	**19 ($10,169-12,945)**
Area Office Director			**21 ($11,638-14,427)**

Home Teachers

The position of home teacher is presently classified at grade 10 ($5,590.00-7,072.00). To attract and retain qualified personnel in this position, a two level classification should be established for home teachers at pay grades 11 and 13.

DIRECT CLIENT WORK AS A CAREER

A civil service job classification for rehabilitation counselor III and for social worker III should be established for professional staff who wish to work directly with clients

during their entire career. This position should combine counseling with responsibilities for the supervision of less experienced counselors or case workers. At present, a rehabilitation counselor or social worker who wants to increase his pay grade classification must apply for an administrative position. Professional staff who are skilled in counseling and enjoy case work should not be forced to change their careers to raise their income level. From a practical standpoint, the need to seek an administrative position defeats the creation of professional standards and depletes the backbone of the agency's services, the client centered counselor or case worker.

Although considerable professional experience is prerequisite to providing supervision to others, there also unique skills involved in supervision which should be learned prior to assuming responsibility for professional supervision as a rehabilitation counselor III or social worker III. To meet this need, special courses in supervision should be offered by graduate schools in rehabilitation and in related fields. In addition, the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should provide inservice training in this area.

Rehabilitation counselor III and social worker III are also intended to be pay grade classifications for top level administrators in area offices working directly under the area office director.

PROFESSIONAL RESPONSIBILITIES

The following job descriptions are intended primarily to illustrate the differences in professional responsibilities. They should not be considered as definitive.

Rehabilitation Counselor I

- Provides individual counseling and other rehabilitation services to clients
- Administers appropriate testing procedures where indicated.
- Formulates, implements and follows up the rehabilitation plans for the client.
- Works cooperatively with other agencies serving the client.
- Provides for comprehensive evaluation, training, placement and followup of clients while retaining overall responsibility for the clients program.
- May serve as counselor assigned to area disability evaluation center or mental health-retardation center.
- Works under the supervision of a rehabilitation counselor II or III or supervising rehabilitation counselor.

Rehabilitation Counselor II

Carries out responsibilities of rehabilitation counselor I in addition to the following:

- May act as consultant to general hospitals, schools and other alerting stations in the area under the supervision of the area rehabilitation director.

Rehabilitation Counselor III (Administrator)

- Administers his program area (physical disability, mental health, etc.) with respect to the following:

  Recommends and initiates agreements with agencies and professionals to be utilized to provide client services.

  Approves purchase of client services and training programs, and administers program guidelines for specific disability groups.
- Provides consultation to counselors and information about available resources in his area of specialization and alerts counselors to new techniques.
- Integrates related programs and services of other public and private agencies.
- Supervises the establishment of new services resulting from amended and expanded federal regulations.
- Coordinates evaluation procedures, training services, purchase arrangements utilized by counseling staff.
- Responsible for evaluating the resources used by staff.
- Provides consultation to community agencies.
- Works under the supervision of the area office director.

Rehabilitation Counselor III (Direct Client Work)

- Provides individual counseling and other direct rehabilitation services to clients of the agency.
- Supervises group counseling programs provided to clients.
- Delivers lectures, case demonstrations and individual instruction to counselors, trainees, and students.

Area Rehabilitation Director

Responsible for the rehabilitation program in his area including the following:

- Serves as director of area office including hiring of clerical and counseling staff.
- Works with the area rehabilitation board.
- Establishes and maintains comprehensive rehabilitation services in his area through contract for service arrangements.
- Reports the activities of the area office to the regional director.
- Provides consultation and leadership to the program supervisor and liaison counselors.
- Integrates inservice training program for his staff.

Case Aide

- Works in direct support of Social Worker on simpler aspects of cases, usually assigned to area office.

- Handles incoming telephone calls from clients, ascertaining their needs. May make client appointments for social workers. May perform variety of clerical and other pertinent duties such as the collection and distribution of mail and messages

Social Worker I

- Counsels and aids individual blind persons requiring social and financial assistance from an agency for the blind.
- Interviews clients with personal and social problems.
- Secures physical, psychological and social information contributing to client's situation and evaluates same.
- Aids client to modify attitudes and patterns of behavior by increasing understanding of himself, his problems and his part in creating them.
- May conduct intake interviews.
- Develops and implements plans for the social restoration and rehabilitation of client.
- Determines eligibility for financial and medical assistance.
- Participates actively in the referral process as a member of the agency rehabilitation services team.

Social Worker II

- Carries out the responsibilities of Social Worker I, in addition to the following:
- Participates in intra and inter-agency planning for improved social and rehabilitation services by interpreting social factors pertinent to program development.
- May act as consultant to other public and private social welfare agencies.
- Utilizes such resources as family service and community agencies to motivate client to resume community life or adjust to, or live with, his disability.

Social Worker III

- Provides individual counseling and other direct social and rehabilitation services to clients of agency for the blind.
- May supervise group counseling programs provided to clients.
- May assist professional staff through individual and group conferences in analysis of case problems and improving the diagnostic and helping skills of staff.
- Recommends and initiates agreements with other agencies and professional personnel to be utilized to provide needed client service.

VARYING ENTRY LEVELS

To enhance recruitment of qualified candidates at all levels, the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should offer appropriate starting salaries based on educational background, experience and present responsibilities, rather than the present single salary for all new personnel.

A review of the entry classification utilized in other states around the country indicated that:

- 13 states have 2 entry classifications
- 16 states have 3 entry classifications
- 10 states have 4 entry classifications
- Massachusetts and 10 other states have only one entry level.

Civil service regulations should be changed to establish specific entry classifications and increments which will permit the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to hire counselors and social workers on the basis of educational background and experience.

EDUCATIONAL REQUIREMENTS

Massachusetts is the only state in the country that does not require any post high school educational training for employment as a rehabilitation counselor. A serious recruitment problem and a potential schism among staff is created when no differentiation is made in either salary or job title among personnel with a high school or graduate school background.

Chapter 780, Acts of 1967, amended Section 6A of Chapter 31, to permit the director of the Civil Service Commission to establish educational requirements for any position where in his opinion such "educational requirements are essential for the proper filling of a position."

The new Sect. 6A also states that, "Nothing in this section shall be deemed to prevent the director (of civil service) from establishing at his discretion substitutions for educational requirements where such substitutions are advisable and proper."

Since the establishment of educational requirements is no longer prohibited, graduate training should become a requirement for the employment of rehabilitation counselors at the Massachusetts Rehabilitation Commission. The responsibility of conducting vocational evaluations, the development of treatment plans and the placement of multiple handicapped individuals such as drug dependents, alcoholics, public offenders and the socioeconomically disadvantaged in addition to physically and mentally disabled clients requires that counselors have graduate training in addition to the inservice training being provided by the Massachusetts Rehabilitation Commission.

All persons hired in the future as rehabilitation counselors I, II, III, or as area rehabilitation directors should have at least a master's degree from an accredited counselor training program or from a related field such as social work, psychology, counseling or special education.

Following are suggested minimum training and experience requirements:

Position	*Suggested Minimum Education*	*Suggested Minimum Experience*
Rehabilitation Counselor I Grade 15 ($7,938-10,028)	Master's degree in rehabilitation counseling, vocational guidance or related behavorial or social science.	None
Rehabilitation Counselor II Grade 17 ($9,110-11,497)	Master's degree in rehabilitation counseling, vocational guidance or related behavioral or social science.	2 years employment as rehabilitation counselor or related fields.
Rehabilitation Counselor III Grade 19 ($10,169-12,945)	Master's degree in rehabilitation counseling, vocational guidance or related behavioral or social science.	3 years employment as rehabilitation counselor.
Area Office Director Grade 21 ($11,638-14,427)	Master's degree in vocational rehabilitation counseling, guidance or related behavioral or social science, plus one year additional education in vocational rehabilitation.	4 years employment in rehabilitation counseling, of which two years were in supervisory capacity.

BROADENING THE TRAINING

The training and upgrading of personnel should receive increased emphasis among all public agencies rendering rehabilitation services. Programs should include inservice training and educational leaves for professional personnel on all levels, student scholarships, summer internships, and special training programs for supportive personnel.

The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind should allocate at least 10% of their annual personnel budgets, about $211,000 for such programs.

The Departments of Mental Health, Public Health, Public Welfare, Education and Correction, the Division of Youth Service, the Division of Employment Security, the Commissioner of Probation and the Parole Board should include similar amounts in their annual budget requests. Chart 1 shows the number of persons employed by the above agencies during 1966-67 and the amount of money spent on personnel. Chart 2 shows the suggested amounts to be spent on various aspects of training and recruitment by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind and by other public agencies.

Chart 1
STATE AGENCY PERSONNEL BUDGETS
1966-67

Department	*Number of Persons Employed*	*Amount Spent On Personnel*
Massachusetts Rehabilitation Commission	264	$ 1,601,784.78
Massachusetts Commission for the Blind	136	506,802.61
Department of Mental Health	14,259	76,903,021.45
*Department of Public Welfare	771	3,997,285.08
Department of Public Health	4,039	20,952,996.23
Department of Corrections	1,862	13,790,359.97
Youth Service Board	750	4,560,979.52
Total	22,081	$122,313,229.64

*Department of Public Welfare personnel increased to about 5,500 in 1968 due to the reorganization of the Department.

Chart 2
SUGGESTED AMOUNTS TO BE ALLOCATED FOR TRAINING AND RECRUITING FUNCTIONS

		Massachusetts Rehabilitation Commission and Massachusetts Commission for the Blind	*Other Public Agencies*
Inservice training	25%	$ 52,750	$ 3,000,000
Educational leaves	42%	88,620	5,040,000
Student internships	4%	8,440	480,000
Student scholarships	10%	21,100	1,200,000
Training programs for supportive personnel	19%	40,090	2,280,000
Total	100%	$211,000	$12,000,000

INSERVICE TRAINING

All personnel working in rehabilitation programs in public or private agencies should participate in regular inservice training programs. Inservice training should familiarize staff with administrative functions and teach current knowledge in rehabilitation and related fields. However, inservice training should not substitute for complete professional education or for university courses staff may take while on the job.

Inservice training provides administrative training and the opportunity for colleagues to discuss common problems, to learn about new methods and approaches and to confer on new policies. This results in raising the educational level and in boosting morale. Staff on all levels should participate in lectures, institutes, professional conferences and seminars.

Funds should be allocated by the respective agencies to pay for the travel and expenses of staff members to national, regional, and local professional meetings. Regardless of seniority in service or position within the agency, all case carrying and administrative personnel should be eligible for these funds.

Frequent use should be made of university resources, outside lecturers and colleagues from other vocational rehabilitation agencies to conduct a sound, broadly based inservice training and professional development program.

Interagency training programs should be conducted whenever feasible.

All personnel, with the exception of clerical personnel, should receive an average of ten days of inservice training annually, in the form of short courses, seminars and attendance at professional meetings. Considerable differences in course content and the length of training would occur in the training of new personnel, in orienting staff to new responsibilities and in communicating the results of relevant research, new professional techniques and in conducting self evaluations of agency programs.

Where applicable, travel and per diem expenses should be paid by the agency.

At least five per cent of all personnel must be replaced annually because of resignations and retirement. At least another 5 per cent should be added to agency staff annually to accommodate growth of services. On this basis, at least 2,200 new staff members in public agencies must receive orientation each year.

New employees should receive an average of three weeks of orientation during their first year of work.

Average expense for inservice training including course expenses and overhead will amount to $150-200 per worker annually. About 15,000 employees should participate in inservice training at an approximate cost of $2.5-$3.0 million annually. (About 25% of the funds recommended for allocation for training and recruitment.) Cost for the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind will be about $50,000-75,000.

EDUCATIONAL LEAVES

Public agencies should encourage personnel at all levels to undertake further professional education by expanding programs of educational leave. Educational leave should not be regarded as a fringe benefit, but rather as a staff investment which will result in improved agency operation.

The Department of Public Welfare, particularly the Division of Child Guardianship presently makes the most use of educational leaves. The Massachusetts Rehabilitation Commission mainly utilizes training programs lasting two weeks or less, and sends personnel to night school. Little use is made of the six months psychiatric intern program and of other educational leaves.

State policy allows educational leave for one year at ½ salary or a ½-year at full salary. Many advanced programs require as much as two years of full time work to complete. The present policy for educational leaves is better suited for allowing staff to take specific courses or to complete a degree than to undertake a full time program of graduate study. Educational leaves should be extended up to one year at full pay and two years at half pay to make it possible for qualified personnel to undertake advanced degree training within a one or two year period and without undue financial hardship.

Educational leaves should be granted annually to at least two per cent of the full time professional, supportive and clerical staff of the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, and by other public agencies providing rehabilitation services.

Educational leaves are usually granted only to personnel in professional and paraprofessional positions. Clerical personnel should also be eligible for educational leaves, to give them the opportunity to undertake a new career.

Step increases, promotion eligibility and fringe benefits, such as medical insurance, should be ensured for employees while on educational leave.

If about 440 persons (2%) of public agency staff were granted educational leaves annually under existing Civil Service regulations, the cost would be about $5,280,000 annually to pay half the salaries of staff on leave @ $8,000 per annum ($1,760,000) and to pay the salaries of staff to replace those on leave at the same annual rate would cost about $3,500,000. This amounts to about 42% of the budget recommended for training and recruitment. The cost for the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind would be about $88,600.

The difficulty of replacing staff on leave constitutes the major problem in expanding this form of staff training.

SUMMER INTERNSHIP PROGRAMS

Recruitment to rehabilitation related professions can be enhanced by providing high school and college students the opportunity to work in a rehabilitation setting, directly with clients where possible. Many students are eager to find work

during the summer months and may be attracted to such an opportunity. Social work career programs have successfully placed students in agencies during the summer for a number of years.

The number of students who can be accommodated in summer internship will vary greatly from one setting to the next. The Department of Mental Health, serving many clients directly at state hospitals, schools for the retarded and mental health centers, might have many openings for placing students in such a program. Chronic disease hospitals, sheltered workshops and administrative settings could also develop an appropriate role for students. Whatever students are asked to do should be in keeping with their age and capabilities and should be of real use to the agency. A staff person should be responsible for every student to orient him to the setting and to his duties and to provide necessary help.

Five hundred student internships should be made available for ten weeks every summer paying students between $80-$100 per week depending on their on their educational background. Such a program would cost between $400,000-$500,000 annually (about 4% of the proposed training and recruitment budget).

STUDENT SCHOLARSHIPS

Public agencies should invest in the recruitment of personnel by providing college and graduate scholarships to promising individuals to prepare for careers in rehabilitation. Often, such help at the right time influences a career decision. Scholarship help is rendered by industry and by other fields and should be part of an overall recruitment program, particularly for students who have been part of the summer internship programs.

At least 500 tuition scholarships should be made available each year in social work, nursing, rehabilitation counseling, physical therapy, occupational therapy, speech and hearing and related areas. Tuition, books, laboratory fees and similar expenses should be paid up to $2,500 per person annually.

This would amount to about $1,250,000 annually or about 10% of the proposed training and recruitment budget.

TRAINING PROGRAMS FOR SUPPORTIVE PERSONNEL

Role of Supportive Personnel

Even a successful program of recruitment of young persons to the professional schools and the necessary expansion of training facilities would not bring about significant changes in the manpower picture for at least four years and probably longer. Current shortages are so great and projected needs so astronomical that the increased utilization of trained assistants and supportive personnel is potentially one of the most innovative approaches to overcoming this problem.

Debate about the role of the nonprofessional worker varies considerably among different professions with polarization around two conflicting viewpoints. One view implies that use of the nonprofessional would usurp many of the activities of the professional and poorer service would result.

The other viewpoint is that certain duties can be performed by the nonprofessional equally as well as the professional. By having a nonprofessional perform such functions, the professional worker is freed for those tasks which his training enables only him to perform.

Because of personnel shortages, many agencies use nonprofessionals. Since there is no consistent guideline or policy for their use, such workers are often hired only as expedients until a fully trained worker can be obtained. In this way, no appropriate role is worked out for the nonprofessional.

A survey conducted by the Association of Rehabilitation Centers indicates that a high volume of supportive personnel already work in rehabilitation facilities. These individuals directly assist the professional in providing clinical services to patients or clients. However, there is a wide variation in the utilization of supportive personnel by various departments ranging from three supportive staff to every one professional in nursing to less than one to every ten professionals in speech and hearing.

This wide variation between the use of supportive staff in nursing and other service areas needs further exploration. There are probably a variety of reasons, the most important being the absolute necessity of providing 24 hour care for a patient in bed. Whether by choice or necessity, the nursing profession has done the most in developing ways of using supportive personnel. Social casework, rehabilitation counseling or physical therapy may not as readily lend themselves to isolating specific functions or to dividing tasks into components to be performed by supportive personnel. In addition, rehabilitation counseling or social casework, no matter how important, are not matters of life and death as continuing nursing care may be. As our conviction about the need for rehabilitation services moves from desirable to essential, such professions as social work and rehabilitation counseling may develop more meaningful roles for supportive personnel.

As in the case of professional personnel, the availibility of funds and budgeted positions do not assure the availibility of supportive personnel. If people are to be attracted to the field of rehabilitation, a greater effort will have to be made in at least the following directions:

Developing a Meaningful Role for Supportive Personnel as a Partner of the Professional — One of the major problems is the difficulty which professional associations have encountered of agreeing to having technicians or aides assume a significant role with the client rather than solely routine and unskilled tasks. Because many professional tasks cannot be fragmented, some professionals feel that the aide may adversely affect their relationship with the client.

Even where it is not possible to turn over certain professional responsibilities to supportive personnel, rehabilitation agencies should study the extent to which professionals trained in clinical areas are actually spending their time in administrative or clerical tasks and might assign such functions to other individuals who are specifically trained for these duties. Most professional associations have issued at least preliminary statements of their positions and are giving the matter further study.

Providing Career Opportunities for Supportive Personnel. — When significant roles for supportive personnel are established, it will become easier to develop career opportunities through job ladders offering personnel the opportunity and the incentive to advance in skill, responsibility and compensation. Such a policy is particularly important to retain supportive personnel with limited educational backgrounds, who do not aspire to professional degrees but are quite capable of carrying out specific supportive roles. Increased recognition of equivalent experience and prior inservice training in lieu of formal education and certification should also be explored.

Providing Truly Competitive Salaries and Wages — Industry is presently recruiting unskilled persons, training them for specific jobs, often of a skilled nature, and paying them wages commensurate with their value to the firm. Rehabilitation professions must do likewise if they are to compete for the scarce supply of supportive personnel. Competitive salaries should be based on the worker's value to the agency. Such value can be increased through adequate inservice training and the development of meaningful job functions.

Traditionally low paying, dead end jobs in many health related agencies and institutions may be false economy because of consistent turnover of personnel and because certain job openings are not being filled.

Rehabilitation and Social Work Trainees

In the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, supportive personnel could be assigned the following responsibilities:

- Gathering of preliminary client data.
- Helping clients to complete forms properly and other necessary paper work.
- Reminding clients of appointments and helping them to get to where they are referred, if necessary.
- Keeping the client informed of the progress of his application.

Special Training Programs

A one year training program for rehabilitation and social work trainees should be established by the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind for persons who do not meet the educational requirements for professional personnel at these agencies. Trainees should learn skills listed above, enabling them to assist professional personnel in administrative and direct client work under appropriate supervision. Trainee positions should be limited to one year and should not be part of the classified civil service.

The training program should be flexible to teach those skills currently needed by the agency. Training should combine inservice training with a major emphasis on direct work with clients. Trainees should be paid $5,935 annually.

Rehabilitation and Social Work Assistants

Persons who, in the judgment of their supervisor and the area rehabilitation director, successfully complete the proposed one year program for rehabilitation or social work trainees should be accepted for employment as rehabilitation or social work assistants.

The permanent civil service position of rehabilitation assistant and social work assistant should be established within the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind at civil service pay grade 13.

Special university based training programs should be developed providing equivalent training on a master's degree level to offer rehabilitation or social work assistants the opportunity to qualify for appointment as rehabilitation counselors I or as social workers I.

At least 350 traineeships should be made available by the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Division of Youth Service, the Division of Employment Security and the Departments of Mental Health, Public Health, Public Welfare, and Correction. At an annual salary of $5,000 for trainees this program would cost approximately $1,750,000 for salaries and about $500,000 for instructors, equipment and administration, or about 19% of the proposed training and recruitment budget.

DIRECTORS OF TRAINING AND RECRUITMENT

Directors of Training and Recruitment should have the broad responsibility of setting up and administering their agency's inservice training and the training of supportive personnel, should stimulate present staff to go on educational leaves and should recruit persons who can potentially make a contribution to the agency for student scholarships and internships.

Such greatly increased functions make it advisable to establish the full time position of Director of Training and Recruitment at the Massachusetts Rehabilitation Commission and at the Massachusetts Commission for the Blind. The existing positions of Senior Supervisor Staff Development and Director of Special Services at the Massachusetts Rehabilitation Commission should be coordinated into one full time position with additional staff help.

Directors of training and recruitment should work closely with universities, professional associations and colleagues in

developing the content for inservice training programs at all levels. Their own educational background and related qualifications should be compatible with these responsibilities.

COUNSELOR SUPERVISION

Regular professional supervision is the foundation of any inservice training program and should be available to every counselor at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind.

Counselors are responsible not only for the rehabilitation and ultimate job placement of clients but also for motivating clients and enhancing their ultimate adjustment. Many clients are multiply handicapped and require a variety of services. Because the counselor's responsibilities are usually not routine or mainly administrative, but must also deal with the client's motivation, family situation and emotional problems, counselors need the advice and support of more experienced staff members on a regular basis.

Senior rehabilitation counselors and social workers should regularly consult with staff members under their supervision on the disposition of their cases and should approve major decisions. This approval is particularly important before reaching any decision to terminate a client because of undemonstrated rehabilitation potential or because appropriate services do not appear to be available. Such a decision may have momentous consequences for a client and all staff resources should be utilized to consider alternative solutions.

It should be the responsibility of the staff at the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to refer all clients whom they cannot serve to other appropriate resources which may be available.

CURRICULA AND COURSE DEVELOPMENT

Rehabilitation methods, processes and techniques need to be brought into a variety of educational programs within colleges and universities as well as in innovative programs at rehabilitation facilities. Although disciplinary and multidisciplinary approaches are both useful, major emphasis should be placed upon the multidisciplinary avenue since the rehabilitation process is usually a term approach.

EMPHASIS ON THE TEAM APPROACH

An interdisciplinary approach should be stressed in rehabilitation practice and training to enhance comprehensive care and to avoid duplication of services. At this time, many services are still fragmented with caregivers working in isolation or making only peripheral use of the skills of related professions. One of the major obstacles to interdisciplinary practice is the inability of many professions to define their function with respect to other professions. This problem is complicated by the differences in professional roles in different settings and for different kinds of clients or patients.

Universities conducting training in rehabilitation related fields should acquaint their students with the contributions of related professions to prepare them to function on interprofessional teams. In addition, students should receive information about the nature and distribution and relevance of all community health and welfare services.

Many professionals do not understand the rehabilitation process beyond their own professional competency. They render services which ameliorate only a part of the client's problems and fail to refer him to other needed services.

A core program in the field of rehabilitation to provide generic rehabilitation skills and a rehabilitation orientation applicable to all professions should be developed by colleges and universities in collaboration with professional organizations. Such a program should recruit students from a variety of disciplines related to rehabilitation to teach subject matter of general importance such as the effect of the disability upon the client and his family, the continuum of services needed to return a client to work, and the utilization of various rehabilitation professions as well as legal and economic community resources to bring about a lasting rehabilitation.

INTERDISCIPLINARY REHABILITATION TRAINING CENTERS

Presently, no facility in the Commonwealth provides a training setting for various types of professionals to work together as an interdisciplinary team to cope with various rehabilitation problems and to become aware of each others professional contribution.

Interdisciplinary rehabilitation training centers should be established bringing together administrators, supervisors, consultants and practitioners with varied professional backgrounds. A program of academic and practical work should emphasize the contributions and limitations of the many professions involved in the rehabilitation process, review current developments in the field of rehabilitation, and provide the basis for an extension of the interdisciplinary approach to other rehabilitation facilities and settings.

Interdisciplinary training centers should be established jointly by universities and local facilities such as the disability evaluation centers and the mental health-retardation centers so that field experiences as well as academic work can utilize the interdisciplinary team approach.

The curriculum should be jointly developed by the sponsoring universities, the local facilities, and the proposed Rehabilitation Coordinating Council. A federal grant should be secured to finance the initial operation of the centers as a nationwide demonstration project.

JUNIOR COLLEGE PROGRAMS TO TRAIN PERSONNEL

Junior and community colleges should plan a greater role in training persons to fill supportive professional roles such as technicians, teachers' assistants, case aides, physical therapy assistants, and occupational therapy assistants. The latter are presently being trained in two junior colleges in the United States.

Efforts of the Massachusetts community college system to develop programs for new positions in the health and welfare fields should be strongly supported by all professional associations, who should provide guidance in the development of course curricula.

Despite the apparent difficulty that exists in clearly defining professional roles and consequently of defining roles for supportive personnel, continued efforts should be made in this direction.

Close liaison should be established between the junior and community colleges and rehabilitation agencies so that the curriculum is related as closely as possible to the job functions which will be performed.

EXPANDED CLERICAL STAFF

At present, there are 20 openings for junior clerk typists and junior clerk stenographers at the Massachusetts Rehabilitation Commission at grades 03 and 04 respectively with starting weekly salaries of $69.60 and $73.20. At such noncompetitive salaries, it has been impossible to attract a sufficient number of clerical staff. Many counselors must do a great deal of their own clerical work.

Many clerical positions in private agencies cannot even be filled at weekly salaries of $90.00 to $95.00. Even senior clerk typist and senior clerk stenographer positions at grades 06 and 07 ($80.70 and $84.90) may remain unfilled. Clerical positions must also be upgraded to become competitive with similar work throughout the Commonwealth.

Until clerical positions can be generally upgraded, agency budgets for clerical help should be increased to allow the employment of more senior clerk typists and stenographers.

To provide adequate clerical help and assistance, one clerk typist or stenographer should be employed for every two counselors or social workers at area offices and state offices of the Massachusetts Rehabilitation Commission.

AUTHORITY TO HIRE

State agency administrators should have the authority to hire appropriate personnel directly to fill existing vacancies, pending final approval by the Bureau of Personnel and Standardization.

At present, administrators are not authorized to fill civil service job vacancies until the application has been processed and approved by the department, the Division of Personnel and Standardization, and the Civil Service Commission. Such a procedure usually takes several weeks. During that time many desirable prospects for employment may be lost because they are unable to wait that long for a definite job commitment. Administrators should be authorized to make immediate job commitments pending the necessary approval.

VETERAN'S PREFERENCE

Under its civil service laws, Massachusetts has adopted a system of absolute veteran's preference. Regardless of their score, veterans who pass the examination required for a position, go to the head of the list — disabled veterans, then veterans, then mothers and widows of veterans, and lastly nonveterans. Nor is this just a onetime benefit to help the veteran get started upon his return from military service. Preference is lifelong and can be used over and over again in every open competitive examination. On all promotional exams which are held within the system, not open to the general public, veterans receive an extra two points.

The desire of the public to give preference within our government service to men and women who have served in the armed forces and to their dependents has wide public acceptance. However, there are problems in translating such a policy into practice.

Preferential treatment for a select group is not compatible with the objectives of a merit system for the selection and promotion of personnel. In Massachusetts, the veteran's preference requirement has, in effect, made a preserve of public service for a limited group of our citizens. Of 48,000 males employed in the official civil service of the Commonwealth and cities and towns, 34,000 or about 70% are veterans. Young persons and nonveterans are discouraged from even applying for public positions against such odds.

A compromise in veteran's preference such as the federal system should receive serious consideration as a means of protecting veterans who need it, but also eliminating veteran's preference in those positions where quality cannot be sacrificed.

In federal government, a veteran gets five points added to his exam score and his name appears ahead of nonveterans receiving the same score. Disabled veterans have ten points added to their score.

At the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, positions for rehabilitation counselors and social workers and their supervisors should not be included within veteran's preference. The quality of the public service depends so heavily on this echelon of position that employment should be based on the results of competitive examinations.

Massachusetts civil service laws should be amended to eliminate absolute veteran's preference and to adopt the federal system which provides disabled veterans with a ten point preference and other veterans with a five point preference over their attained grade in competitive civil service examinations.

Individuals seeking professional and managerial positions should not need the sheltering of a preference. The needs of the public must take precedence over those of a limited group.

SUMMARY OF REHABILITATION RELATED TRAINING PROGRAMS IN MASSACHUSETTS

REHABILITATION COUNSELING

Programs in rehabilitation counseling are offered at Boston University and at Springfield College. Three levels of training are available at Boston University: master's, certificate of advanced graduate study (CAGS), or doctoral. Each program offers a sequence of courses and a practicum designed to develop the knowledge, skill and competency for effective counseling of the handicapped. Twenty-four students were graduated from the master's degree program in 1967 Thirty-eight students are enrolled in this program in 1968. The doctoral program has 25 candidates in 1968. Two were graduated in 1967.

Springfield College's program leads to the master of science degree and concurrently to a certificate of advanced specialization in rehabilitation counseling. About 25 students are enrolled in 1968 rehabilitation counselor training. Fourteen students were graduated in 1967.

A new development is a bachelor's degree program in rehabilitation counseling which is presently being conducted at the University of Pennsylvania and is under consideration at Northeastern University.

REHABILITATION ADMINISTRATION

Northeastern University offers the only program in rehabilitation administration in the country. The goal of the program is to train administrators for all types of rehabilitation facilities and settings such as geriatric homes, schools for the retarded, and sheltered workshops.

Of the first graduating class of 20, 19 remained in the field of rehabilitation. However, only one accepted a position in Massachusetts.

REHABILITATION NURSING

Boston University School of Nursing offers the only graduate training in rehabilitation nursing. A degree program, short courses, and workshops are provided

The degree program leads to a master of science in rehabilitation nursing. Emphasis is placed on preparing nurses for leadership roles as teachers, supervisors, administrators, and consultants for the care of chronically ill and disabled persons, in multidisciplinary settings. About 25 nurses are graduated annually. Of the 150 who graduated so far, 45 remained in Massachusetts.

For nurses with a master's degree, the school also offers a certificate of advanced graduate study (CAGS) in rehabilitation nursing, and a one semester program for postmaster's students who have responsibilities in the area of nursing education.

Short term courses for graduate nurses who are working in nursing homes, public health agencies and other settings are also available as a form of inservice education. Ninety-two graduate nurses from Massachusetts have participa[illegible] For students enrolled in the undergraduate program in nursing, the rehabilitation aspects of nursing are integrated into the curriculum. All students enrolled in the four-year basic program receive a clinical experience in the care of long term illnesses. For those registered nurses who have graduated from a non-diploma school and later attend the university to get a degree, a two-credit course in rehabilitation nursing is required. More than 1,000 nurses have taken this course.

PHYSICAL THERAPY

Boston University's Sargent College offers both undergraduate and graduate programs in physical therapy in cooperation with the Boston University School of Medicine. Simmons College and Northeastern University offer undergraduate programs. Approximately 80 undergraduate and 4 graduate students are graduated from these schools annually. However, the master's program at Sargent College is only one year old, and the number of graduates is increasing.

OCCUPATIONAL THERAPY

Boston University and Tufts College (College of Special Studies) offer occupational therapy training. Boston University has a four-year program from which fifteen students were graduated in 1967. Eighty-five students are enrolled in 1968. Boston University also offers a certificate in occupational therapy involving 18 months training beyond the bachelor's. A master's program in occupational therapy began in 1967 with a present enrollment of six students.

Tufts University's bachelor program graduated thirty-one students in 1967, and five graduated from the advanced certificate program. Ninety-nine bachelor's degree students are enrolled in 1968 and five for the advanced certificate.

Tufts is planning to offer a master's degree program in occupational therapy in the near future.

SPEECH PATHOLOGY AND AUDIOLOGY

Speech pathologists are chiefly concerned with disorders in the production of speech and language; audiologists, with disorders in the reception and perception of speech and language. Interests of speech pathologists and audiologists combine easily into one profession, and many professionals are qualified in both areas.

Four colleges and universities in Massachusetts offer graduate and undergraduate training programs in speech

and hearing. There about 300 undergraduates with a major in speech and hearing at: Boston University, University of Massachusetts, Northeastern University, the Emerson College. With the exception of Northeastern whose program is only three years old, these schools graduated about 80 students during 1967.

A master's degree is required by the National Association of Speech and Hearing for certification. Master's degree programs in speech and hearing are being offered at all four schools, with an enrollment of about 90 full time and part time students. About 20 received advanced degrees during 1967.

Boston University offers a doctoral program in speech and hearing with a present enrollment of five students.

SOCIAL WORK

Social work training in social casework, group work, and community organization is conducted at Boston University and Boston College. Simmons College and Smith College offer a two year master's degree program in social casework. In 1967, these four schools had a combined enrollment of 615 full and part time students. Two hundred forty-six students were graduated with a master's degree in 1967.

The Florence Heller School at Brandeis University offers a doctoral program in social welfare. In 1967, the school had an enrollment of 45 students. Seven persons were graduated. A new four year program combining master's and doctoral level studies started in 1968.

Relatively few social work students specialize in the field of rehabilitation. At Boston University School of Social Work, for example, students select a major field of practice in addition to their major method of casework, group work, or community organization. Students selecting rehabilitation are placed in agencies which serve persons having physical or mental disabilities and offer experience with the process involved in rehabilitation.

About 20 Boston University social work students select rehabilitation as their major field of practice each year.

FEDERAL GRANTS

The Rehabilitation Services Administration makes training funds available under Section 4 (a) (1) of the Vocational Rehabilitation Act for the following professions: medicine, physical medicine and rehabilitation, physical therapy, occupational therapy, speech pathology and audiology, rehabilitation nursing, rehabilitation social work, prosthetics and orthotics, rehabilitation psychology, rehabilitation counseling, recreation for the ill and the handicapped, sociology, dentistry. In addition, grants are made for support of specialized training for rehabilitation of the blind, deaf, mentally ill and mentally retarded.

Funds available from the federal government for training manpower in the field of rehabilitation are distributed into five different types of matching grants:

- *Teaching Grants* are awarded to educational institutions to develop their instruction in rehabilitation training. Such grants are intended to defray part of the costs of instruction including salaries of faculty and supporting activities.
- *Traineeship Grants* are awarded to educational institutions to provide living expenses, tuition and dependent allowances for needy students.
- *Inservice Training Grants* are made available to state vocational rehabilitation agencies to enhance staff development.
- *Short Term Training Grants* are made available to educational institutions and agencies for short term training courses, for institutes, workshops and seminars.
- *Rehabilitation Research Fellowships* are made available to professional agencies carrying out advanced training in rehabilitation research as well as projects which hold promise of making significant contributions to the vocational rehabilitation of disabled persons.

INFORMATION AND EDUCATION — VITAL LINKS

RECOMMENDATIONS

COMMUNICATIONS AND EDUCATION UNIT

189. A Communications and Education Unit should be established within the proposed Planning, Training, Research, and Education section of the Massachusetts Rehabilitation Commission to develop and implement an integrated program encompassing all the major communication and education objectives specified in the recommendations of this report.

FACT FINDING NEEDED

190. A major program of the Communications and Education Unit should include studies to provide needed data on public awareness and knowledge levels pertaining to all aspects of the rehabilitation program.

Studies dealing with public awareness about rehabilitation services, public attitude towards the disabled and professional interest in working in the field of rehabilitation should receive priority in the work of the Communications and Education Unit to lend direction to programs and to provide a baseline for measuring the effectiveness of educational and communication efforts.

COMMUNICATIONS AIDES

191. Local people living in each area should be employed as communication and education aides to serve as mediators between the professionals and the people they serve, to help improve casefinding and the success of referrals.

ADVISORY BOARD

192. Representatives of the various self help groups and additional persons knowledgeable about rehabilitation should be appointed to a Communications and Education Advisory Board by the Commissioner of Rehabilitation to advise the Communications and Education Unit about the needs and interests of disabled, disadvantaged and handicapped individuals.

REHABILITATION LIBRARY

193. The current library facility at the Massachusetts Rehabilitation Commission should be expanded and developed into a statewide rehabilitation resource with appropriate allocations for additional staff and for the purchase of books, periodicals and related reference material.

TARGET GROUPS AND GOALS

Any broad health and welfare program requires the recognition and identification of a number of tasks to which generic communication and education processes can be applied to induce changes in attitudes and behavior.

Specific communication and education tasks are geared toward a variety of special target groups and toward concrete program goals such as:

- Letting disabled individuals know that they can be helped.
- Informing physicians and ancillary medical personnel that institutions and skilled personnel can assist their disabled patients to return to normal living after the acute stage of illness is past.
- Stimulating interest in rehabilitation among students in related areas with the goal of future recruitment.
- Educating the general public toward an understanding of what disability and rehabilitation may mean for himself, his family and his community.
- Making sure that people know where to turn for help in meeting the problems of disability.

DATA NEEDED

Currently, no firm data exist about the level of knowledge and awareness about rehabilitation among any of the segments of the general public. Data should be collected and analyzed to assist in efforts to develop an information and awareness program aimed at the general public or at any of its special target groups.

Relative effectiveness of different techniques, methods and media in developing and maintaining general public awareness in any specific health or welfare field is open to question. All methods and media are useful in specific program situations. However, research evidence supports the assumption that the appropriate use of a combination of media increases awareness and learning more than the use of any single technique alone.

A number of different messages should be beamed to the general public including the following:

- A detailing of the nature of vocational rehabilitation.
- An explanation of the rehabilitation process.
- A listing of the community resources and services available to people in need.
- How health screening measures are instrumental in the prevention of illness and disability.
- A report on the current status of rehabilitation programs, services and the results of research in rehabilitation.

Obviously, this information will appeal to different levels of interest and to different segments of the general public. Since people tend to respond to information that reinforces existing opinions, beliefs, attitudes, values, motives, and behavior, the principles of selective exposure, selective perception, and selective recall will operate continually. Therefore, it will be necessary to disseminate the desired information in updated versions to a broad spectrum of intended receivers using a variety of combinations of media and messages.

It is particularly important to change attitudes of specific groups such as the Massachusetts legislature, advisory boards and citizen committees, private rehabilitation agencies, friends and families of the disabled, and the disabled themselves. Specific information and actions most relevant to each of these special groups and the methods of communication most suitable to effect the desired outcomes engender considerable debate. To recommend that these crucial, influential groups be reached is one thing. To devise a substantive program for reaching them is a much more difficult task requiring special communications, education, and evaluation skills.

ATTITUDE CHANGES

Testimony of many individuals and organizations who appeared at the six statewide public hearings sponsored by the Planning Commission clearly indicated that basic attitudes toward the disabled need to be changed.

How are the attitudes towards public offenders related, if at all, to attitudes towards other disabled individuals? Are attitudes towards the rehabilitation of the elderly different from those towards the severely handicapped? Are community attitudes towards discharged mental patients amenable to change by the use of the same techniques that might be applied to changing employer's attitudes toward the disabled? How do attitudes held by the public towards the disabled differ from those held by professional rehabilitation workers, by the legislature and by school personnel? Can the same methods used in attempting to change attitudes about the rehabilitation approach to crime prevention be employed in trying to develop preventive attitudes among the public at large?

Until more is known about the nature of attitudes and their formation, their relation to beliefs and opinions and how, in turn, they relate to behavior, specific educational techniques and methods to effect needed changes will be difficult to develop and apply. Furthermore, new methods of measuring attitude and opinion change are needed if the effectiveness of educational methods are to be truly evaluated.

In the final analysis, attitudes must focus on the individual as an individual. Functions of attitudes must be known before persuasion can begin. Attitudes do not exist singly, but are part of behavior patterns which must be identified and understood before methods of effecting change can be tested systematically. Once the behavior patterns are known, the full range of communications and educational methods and techniques can be brought to bear on the difficult target of changing attitudes.

The first national advertising campaign to reach all disabled Americans with rehabilitation information has been prepared by The Advertising Council in cooperation with the U.S. Department of Health, Education, and Welfare. Warwick and Legler, Inc., the volunteer advertising agency, developed the creative material. "You have nothing to lose but your disability," is the theme of the campaign and the mass media started using the material in December, 1968. Throughout this report various samples of the material have been reproduced to illustrate the approach being undertaken to reach all Americans with reliable rehabilitation information and to motivate people to seek aid. The new advertising campaign will seek to reach the disabled, their friends, relatives and the general public to tell them help is available, how to get this help and to persuade those who need help to take advantage of the rehabilitation program.

In addition, the federal authorities provided a research budget to determine the effectiveness of this first nationwide advertising campaign aimed at all the disabled. A two part survey is being conducted by Roper Research Associates under the guidance of Warwick and Legler. Prior to the appearance of advertising, a survey was undertaken to determine the awareness level of both the general public and households that contained handicapped individuals to ascertain their knowledge of available rehabilitation help. Also, about 100 physicians are being interviewed to gather data on their feelings about their competence and responsibility in the area of rehabilitation and to assess their knowledge of available facilities. A follow up survey is planned in about a year to measure the effectiveness of the advertising campaign among all groups.

COMMUNICATIONS AND EDUCATION UNIT

A hard look at the communications and educational aspects of recommendations from all various sections of this report indicate a predominant need for a well staffed, appropriately organized unit dedicated to the development and operation of a total communication-education program in the field of rehabilitation. Currently, the best administrative location for a Communications and Education Unit is under the direction of the proposed assistant commissioner for planning, training, research and education. A director of communications and education should head the proposed unit. The existing Massachusetts Rehabilitation Commission unit on Community and Interagency Relations should

be integrated into the proposed Communications and Education Unit.

Typical Tasks

Among the activities of the proposed Communications and Education Unit should be the following tasks:

- Preparation of basic printed material describing the state rehabilitation program for widespread distribution to a variety of audiences throughout the state, including schools, hospitals, courts, physicians, and mental health clinics.
- Creation of various mechanisms for providing area rehabilitation programs with the services of the Communications and Education Unit to allow alerting stations, liaison counselors, disability and evaluation centers and workshops to have the full advantage of information and educational programs and materials.
- Implementation of investigations seeking data about public and professional attitudes towards the disabled to gain an indication of the level of knowledge about rehabilitation.
- Compilation and publication of a listing of the agencies certified by the Rehabilitation Facilities Board and the established fee schedules.
- Alerting private industries about the need for subcontracts and seeking their representation and cooperation in hiring public offenders by promoting the work of the proposed Council on Cooperating Employers and Labor Unions.
- Development of a easily understandable brochure in cooperation with the Industrial Accident Board, to inform injured workers of their rights.
- Preparation of appropriate recruitment material for use in high schools, undergraduate and graduate schools and with students, instructors and guidance counselors.
- Publication of a resource directory of community health and welfare agencies for the use of students already committed to the rehabilitation field.
- Active cooperation with various professional groups in the preparation of rehabilitation reference guides for the membership including the location of services, the methods of referral and the funding source.

At the program's inception, at least two specialists with competence in community organization, group processes, consultation skills, and communication techniques and with experience in working with clients in schools and colleges, hospitals, correctional institutions, and community agencies, should be employed to work under the director.

Various sections of this report spell out the nature and content of some of the top priority educational and communicational tasks to be accomplished. Personnel in the proposed Communications and Education Unit should place these recommendations in total perspective following guideline priorities set by the Commission of Rehabilitation in devising a comprehensive, integrated program related to all facets of the rehabilitation program in Massachusetts.

Production of special and specific films, posters, news releases, and pamphlets and the development of a speaker's bureau to provide individual talks and lectures and to lead group discussions should be a part of the program. From its inception, the proposed Communications and Education Unit should be charged with the responsibility of developing a total approach to the achievement of all complex educational and communications tasks related to the almost 200 recommendations. Focusing full time attention and efforts on rehabilitation goals and utilizing the full range of resources available from related official and voluntary agencies, a Communications and Education Unit should be able to make a significant contribution to all facets of the rehabilitation program.

INFORMING AND EDUCATING PROFESSIONALS AND AIDES

Patients who suffer severe disabilities are treated by physicians and a wide variety of ancillary professional personnel. Obviously, strenuous efforts should be made to insure that the patient receive further needed services after the acute stage of illness subsides. Similarly guidance counselors, teachers and other school personnel, psychologists and various nonmedical professionals who deal with social problems or resolve an emotional crisis should be alert to the potential rehabilitation services which may be required by their clients.

Numerous efforts to reach busy practioners indicated that a highly specialized approach is needed to secure active involvement in seeing that patients are channeled into appropriate rehabilitation programs promptly.

Preservice Preparation

School personnel, guidance counselors, adjustment counselors, social workers, nurses, physicians, alerting station personnel and other professionals concerned with casefinding, referral, treatment, followup and educational networks should be thoroughly oriented before being assigned to rehabilitation programs. Major emphasis should be placed on the basic education of rehabilitation workers themselves.

Training of Aides and Auxiliaries

The problems of professional education are closely related to the training of a variety of types of supportive personnel requiring less formal education. Among those supportive personnel in rehabilitation are the rehabilitation aide, the research technician, and the neighborhood or community extension agent. All should be trained through the extended use of the facilities of public community colleges or private junior colleges. Other types of aides may also be utilized such as the social work assistant, the communication aide and the school auxiliary, with the number and type depending on the agency functions and roles to be fulfilled.

Interdisciplinary Communication

Complexities of interdisciplinary communication and the intricacies of inter and intra agency communication pose educational problems of the first magnitude. Solutions in the form of the establishment of information clearing houses or in the compilation of master directories are helpful, but probably do not eliminate deep seated communication barriers existing currently in the rehabilitation system. New communication networks designed to relay information from the central offices of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind to and from area and regional coordinators, and to and from the proposed alerting agencies and neighborhood casefinding and referral centers will take considerable time to achieve. Acquainting all state and private rehabilitation related agencies about their involvement in the recommendations of this report should also be a high priority task for the Communications and Education Unit.

COMMUNICATION AIDES

Coordinating councils, advisory boards and committees, and public hearings are recommended in this report and should be organized as they afford an opportunity for needed feedback. However, these procedures seem to limit the people reached and no systematic data are available to assess their overall communication value. Perhaps too much dependence has been placed on these standard procedures and not enough on experimentation with more innovative communication mechanisms designed to reach (and influence) the so called hard-to-reach segments of the target population. A number of recent studies indicate that low income families and other hard to reach groups respond best to person-to-person methods and techniques of communication. Yet, little attention has been devoted to designing and evaluating devices such as the use of indigenous communication and education aides to serve as mediators between the social classes and between the professionals and the public they serve. In addition, the consumers of rehabilitation should be involved in all facets of program planning and implementation. Local people living in each area should be employed as communication aides to work with the area rehabilitation directors. liaison counselors and advisory boards to achieve a viable two way flow of information.

Obviously, different types of approaches to both public and professional audiences need to be tried. Valid and reliable feedback information from all target groups should be part of the rehabilitation system at all levels of operation. Since communication implies both content and method, both dimensions should be studied as they apply to problems in the rehabilitation field.

ADVISORY BOARD

Often, personnel involved in communications and educational programs lose touch with the intended targets of their efforts. Once plans are prepared, it is difficult to change the direction. To keep in direct interaction with the handicapped themselves, representatives of self help organizations such as the Massachusetts Association of Paraplegics, Associated Blind of Massachusetts, Boston Cured Cancer Club, Massachusetts Association for Retarded Children and Mended Hearts should be appointed to a Communications and Education Advisory Board by the Commissioner of Rehabilitation. This Advisory Board should meet regularly with the director of the Communications and Education Unit to review current programs and to advise staff members about the pressing needs and interests of disabled, disadvantaged and handicapped individuals.

In addition to serving as advisory persons to the statewide unit concerned with communications and education, the members of the Advisory Board could also function as liaison between the area rehabilitation director and the people in the community. Working with the proposed communication aides, the members of the Advisory Board could carry out a vital task in keeping area rehabilitation advisory boards and professional staff alerted to the impact and value of their activities from the viewpoint of the consumer.

Consideration should be given to convening other groups to aid evaluating the impact of communications and education messages. Professional representatives might be called together to discuss the recruitment program, researchers might meet to determine whether the results of research are being reported adequately and area rehabilitation advisory boards might discuss how to improve information activities in the local community.

These activities demand considerable time to carry out well, but the feedback about the results of communications and educational messages is a needed part of any effective educational program.

REHABILITATION LIBRARY

Various sections of this report have noted the anticipated increase in specific activities and the large numbers of other governmental and private agencies involved in rehabilitation. As more and more individuals and agencies participate in rehabilitation programs, they will require a central source of information. As a start, the current reference library at the Massachusetts Rehabilitation Commission should be expanded and developed into a statewide rehabilitation resource. Appropriate funds should be allocated for additional staff and for the purchase of books, periodicals and related reference material. Staff members should investigate the possibility of integrating their resources into the *MEDLARS* automated retrieval system located at the Countway Medical Library at Harvard Medical School. At a minimum there might be an opportunity to utilize the data on rehabilitation as it relates to the medical and health aspects.

An effective system should be developed of informing staff members of all rehabilitation related agencies about new books and other reference material of value in their day to day operations.

RESEARCH AND EVALUATION

Every communication method and educational program should be subject to ongoing, continuous research and evaluation. This would be especially important in the early program phases when alternatives are being weighed objectively and new combinations of tools and techniques are being examined.

Research should be aimed at improving an educational activity or program in relation to its potential usefulness. At this stage, major emphasis should be placed on empirical research and studies intimately related to application rather than on basic research.

The need for rehabilitation research is manifested in the number of specific recommendations in the report dealing with research activities on various levels. Each activity was tailored to attain immediate action in highly concrete and discrete terms on a specific research problem area. Communication and education tasks are obvious in the following suggested research programs.

- Establishment of regional rehabilitation conferences for sharing research ideas and information and for reducing the gap between discovery and application.
- Publication of a new national journal of rehabilitation research with Massachusetts assuming the leadership role.
- Development and integration of material on research into rehabilitation, both ongoing undergraduate and graduate curricula in the biological and social sciences.
- Organization of a program of career fellowships in rehabilitation research.
- Development of a master's degree program for training research technicians and specialists in the medical, social science, and biological areas.
- Establishment of an interuniversity rehabilitation research committee.
- Development of advanced inservice training programs in research for rehabilitation workers.

These and other recommendations related to evaluation and research require the application of educational knowledges and skills of a high order.

COMMUNICATION AND EVALUATION AT THE MASSACHUSETTS COMMISSION FOR THE BLIND

In the proposed reorganization of the Massachusetts Commission for the Blind the position of Assistant to the Commissioner for Public Affairs has been suggested. The task of this person will be similar in many respects to the activities of the proposed communication and education unit in the Massachusetts Commission for the Blind.

However since the scope of the rehabilitation problem will be limited solely to blind individuals, the activities will naturally be on a smaller scale. In any event the person occupying the position of Assistant to the Commissioner for Public Affairs at the Massachusetts Commission for the Blind should work very closely with the Director of Communications and Education at the Massachusetts Rehabilitation Commission in the planning and execution of any rehabilitation educational program.

THE ADVERTISING COUNCIL, INC.

Rehabilitation for The Mentally and Physically Disabled Campaign

20-SECOND RADIO SPOT #1

ANNOUNCER

Maybe you have a disability. And maybe you're giving it the best years of your life. Today, with proper medical aid, you could learn to put your time to better use. If you're disabled, write: HELP, Box 1200, Washington, D.C. 20013. You've got nothing to lose but your disability.

FINANCING COMPREHENSIVE REHABILITATION PROGRAMS

RECOMMENDATIONS

SERVICES FOR ALL WHO CAN BENEFIT

194. Adequate state and federal financing should be provided to insure that all handicapped persons will receive rehabilitation services if their ability to perform the activities of life would thereby be improved.

FULL STATE APPROPRIATION

195. The Commonwealth should appropriate sufficient funds to match all federal monies allotted to this state for use in the rehabilitation of handicapped persons.

NEW STATE FINANCING

196. The Commonwealth should appropriate sufficient funds so that necessary rehabilitation programs not financed by existing federal or state legislation may be developed.

REHABILITATION TRENDS

Financing comprehensive state rehabilitation programs must be discussed within the framework of national goals and leadership. The federal-state partnership in vocational rehabilitation is now one of the largest programs among federally supported, state administered, health and welfare programs.

The Vocational Rehabilitation Amendments of 1965 and 1968 extended the reach of rehabilitation programs at the federal level and became the basis of rehabilitation goals in the United States. These Amendments expanded the definition of rehabilitation, emphasized the placing of disabled persons in sheltered or home work environments, and significantly increased appropriations for the federal-state rehabilitation program.

The 1968 amendments extended the definition of handicapped persons to include individuals disadvantaged by reason of age, youth, low educational attainment, ethnic, cultural, or other factors such as prison or delinquency records. This legislation authorized federal support of 90% of the cost of special vocational evaluation and work adjustment programs, increased the federal share of the basic program for vocational rehabilitation services to 80% effective in 1970, and extended rehabilitation services to members of the families of handicapped individuals "when such services will contribute significantly to the rehabilitation of the individual." Increased funds for the construction and improvement of rehabilitation facilities, and for evaluation of programs through research and demonstration studies were also provided by the 1968 act.

These Amendments expanded the opportunity for rehabilitation to thousands of individuals. Without doubt, continued expansion will occur. Recommendations which have already been suggested include:

- Extending the rehabilitation program to the underemployed disabled.
- Liberalizing eligibility to include every person who requires intensive counseling and rehabilitative services.
- Expanding followup and other types of services to help handicapped persons maintain their vocational success.

These recommendations illustrate the direction that rehabilitation programs of the future are likely to take. However, even without additional expansion of the public vocational rehabilitation program, the states have a major job ahead of them just to meet recently enacted changes. Estimates of the cost of the recommendations in this report must be considered in relation to the probable expansion of rehabilitation programs.

REHABILITATION AS AN INVESTMENT

Efforts to extend the rehabilitation program have been favorably received by the Congress and state elected officials. In part, this may be attributed to the proven value of the vocational rehabilitation program. Cost effectiveness studies have shown that the benefits of rehabilitation to society far exceed the cost of services. In the final analysis, both taxpayers and disabled persons benefit.

In contrast to estimates of probable lost earnings and added health costs, the cost of the vocational rehabilitation is slight. As estimated $10 billion is lost to the nation's economy each year because handicapped persons could not find or keep jobs. Increased lifetime earnings resulting from rehabilitation services represents a good return on the public investment.

Income generated by rehabilitation services may be measured in savings to taxpayers. Table I illustrates the two fold value of vocational rehabilitation: reducing public welfare, and producing new tax revenues. An estimated $38.7 million was recouped in 1966 through reduced welfare expenditures and increased income tax receipts from individuals rehabilitated in that year's federal-state program (See Table 1). This amount was recovered in only one year, from a total federal-state rehabilitation expenditure in 1966 of $215.8 million, which is a return of almost 18%.

These estimates do not reflect the total value of rehabilitation services to the taxpayer. The benefits of increased state and local tax receipts, decreased public health expenditures, and the cost of decreased institutional care are not included in Table I.

In 1967, Massachusetts spent $1,142,686 of state funds as its share to provide rehabilitation services and produced these returns:

- 2,169 rehabilitated individuals had a total yearly income at case closure of about $7,000,000, a gain of nearly $6,000,000 over their income at acceptance to the program.
- Increased state sales and income taxes from these individuals totaled more than $50,000 per year.
- Reduced costs to the state for institutional care and public assistance to these individuals represented an annual savings of approximately $500,000.

The above statistics illustrate that each rehabilitation dollar expended is a sound investment. Disability may mean an inability to work, impaired efficiency, or underemployment. Consequently, the tangible effects of disability include reduced family income, increased medical costs, and in many instances, decreased productivity on the part of family members who must care for disabled persons. Rehabilitation can offset these tangible effects of vocational handicaps.

But rehabilitation does much more; its benefits cannot be measured in dollars alone. There are also intangible effects of disability. Disability may mean suffering and pain, decreased individual and family security, rejection by society, and in many cases, limited horizons for the children of disabled persons. Rehabilitation can offset these compelling intangible effects as well.

The Planning Commission urges increased rehabilitation expenditures not only to overcome the tangible effects of disability but also because of the intangible effects. These intangible effects can never be adequately estimated nor recouped.

Table 1
BENEFITS OF REHABILITATION TO NATION'S TAXPAYERS 1961-1966[1] (IN MILLIONS)

Year of Rehabilitation	Estimated Increase in Annual Federal Income Taxes[2]	Estimated Decrease in Annual Welfare Payments[3]
1961	$ 9.4	$ 9.6
1962	10.9	10.1
1963	12.3	10.1
1964	14.8	11.6
1965	17.0	13.7
1966	20.9	11.8

CURRENT AND PROJECTED COSTS

Through the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, the Commonwealth is currently spending about $10 million on rehabilitation services. Approximately $8 million of this amount comes from the federal government. Planning Commission estimates for fiscal year 1976, indicate that the allotment from the federal government for the basic program of vocational rehabilitation services will be approximately $40 million. Using the required 80-20 matching formula, the 1976 budget for the basic program will be about $50 million.

In addition to these monies, separate funds will be allotted for the new program to provide rehabilitation services to disadvantaged persons. These federal funds are expected to grow to approximately $4.5 million by 1976. The state must match these funds on a 90-10 basis, providing a total of $5 million. From these estimates, the total budget of the federal-state vocational rehabilitation program is expected to exceed $55 million for fiscal year 1976. This amount is exclusive of special grants to private agencies and grants for construction or remodeling of rehabilitation facilities.

The comprehensive statewide rehabilitation planning in Massachusetts is but one of more than 50 planning projects that will provide the detailed estimates necessary for expansion of the federal-state program. The Commonwealth must anticipate this increase in federal assistance in order that matching funds may be made available. In the past, the Commonwealth has not appropriated sufficient funds to match all federal funds allotted to this state for rehabilitation programs. Consequently, millions of dollars have been lost for use in rehabilitating our handicapped citizens.

Although significant changes in the basic federal rehabilitation program may be anticipated, some important rehabilitation programs will not be financed by federal assistance in the immediate future. Massachusetts should not wait for federal aid before embarking on necessary programs. The Commonwealth should appropriate sufficient funds for the following rehabilitation programs not financed by existing federal or state legislation:

- Rehabilitation services for persons too severely handicapped to be eligible for the federal vocational rehabilitation program.
- Day activity programs for persons too severely disabled to undertake productive work.
- Subsidies to workshops for providing extended sheltered employment and homebound employment to severely handicapped persons.
- Wage supplements to increase the income of persons engaging in extended sheltered employment and homebound employment.
- Attendant and other in home services for homebound disabled persons.

1 See *Vocational Rehabilitation, Program Analysis*, prepared by the Office of the Assistant Secretary (Planning and Evaluation), U S. Department of Health, Education, and Welfare, December, 1967.

2 Data for 1961-1963 not comparable to data for 1964-1966 because of differences in the way earnings at acceptance were measured.

3 Monthly welfare payments multiplied by 12.

Source: Division of Research and Statistics, Rehabilitation Services Administration.

Estimates of the cost of the recommendations of this report are advanced within the context of increased federal funds to be matched by the Commonwealth. Estimates are based on current costs of operation. No adjustment has been made for inflation. Unless otherwise noted, estimates are for the cost of operation only. Construction costs are not included. The Planning Commission recommends that wherever possible existing state buildings, rented quarters, or contractual or fee-for-service arrangements should be utilized to avoid costly capital outlay expenditures.

Table 2 presents operating cost estimates for the Planning Commission's recommendations by program categories for fiscal years 1971 and 1976. Federal government guidelines instructed state planning projects to utilize fiscal 1976 as a target date for complete implementation of recommendations. In addition, federal government requested state planning agencies to indicate, through a composite working plan, specific short range goals for the intermediate period between now and 1976. In Table 2, the 1971 column represents the anticipated expenditures for implementing a minimal number of rehabilitation advances. These short range, catch up programs represent important advances toward bringing Massachusetts' rehabilitation agencies up to the operating level required for an expanded rehabilitation program to serve all handicapped persons.

Table 2
1971 AND 1976 OPERATING COST PROJECTIONS ARRANGED BY PROGRAM CATEGORIES AND SOURCE OF FUNDING (COST IN THOUSANDS OF DOLLARS)

Program Categories[1]	*Fiscal Year 1971*	*Fiscal year 1976*	*Primary Source of Funding*[2]
PERSONNEL AND ADMINISTRATION			
Administration	$ 1,659	$ 1,659	80% federal; 20% state
Manpower	7,292	17,362	80% federal; 20% state
CLIENT SERVICES			
Casefinding	465	465	100% state
Evaluations[3]	1,350	5,000	80% federal; 20% state
Physical Restoration	1,250	2,540	80% federal; 20% state
Education and Training	4,000	9,300	80% federal; 20% state
Workshop Services[4]	10,414	14,327	50% federal; 50% state
Supportive Services	2,960	10,325	80% federal; 20% state
Placement	525	858	50% federal; 50% state
SPECIAL PROBLEMS			
Architectural Barriers[5]	183	183	55% federal; 45% state
Public Offender	1,550	2,935	65% federal; 35% state
Technological Change	110	110	100% state
Research	447	658	40% federal; 10% state; 50% private
TOTALS	$32,205	$65,722	

BREAKDOWN OF COSTS BY SOURCE OF FUNDING

1971			1976		
Federal Share	—	$18,775,000	Federal Share	—	$44,616,000
State Share	—	12,243,000	State Share	—	19,764,000
Private	—	1,187,000	Private	—	1,342,000
TOTAL	—	$32,205,000	TOTAL	—	$65,722,000

1 Program categories reflect the collapsing of recommendations from a number of specific sections of this report under a single, most appropriate, generic title.

2 In most instances, the operating costs of the recommendations of the Planning Commission will be funded under the federal Vocational Rehabilitation Act, and subject to federal-state matching provisions
(a) For most services, the federal share will be 80%, the state share will be 20%
(b) In some cases, such as the cost of vocational evaluations for socially disadvantaged persons, the federal share will be 90% and the state share will be 10%
(c) Operating costs for programs not currently funded under provisions of the Vocational Rehabilitation Act, or by other federal grant-in-aid programs, will require 100% state funding or, where applicable, funding by private sources

3 Estimates of the cost of evaluations at area disability evaluation centers are based on the salaries of professional evaluation teams and do not include other operating expenses of providing inpatient/outpatient services

4 A relatively high share of state monies is required for state workshop services because it is anticipated that a significant proportion of the clientele will be in extended sheltered employment and will be receiving day activity services. Operating costs of these programs can not be funded under provisions of the Vocational Rehabilitation Act

5 Estimates of the cost of constructing and operating special housing facilities for handicapped persons are not included

FINANCING PERSONNEL NEEDS AND ADMINISTRATIVE IMPROVEMENTS

If rehabilitation services are to be increased significantly in Massachusetts, increased numbers of professional and clerical staff must be recruited, trained, and placed in job positions where they may implement expanded programs. Securing this essential manpower, and reorganizing the administrative structure of the Massachusetts Rehabilitation Commission and the Rehabilitation Services Section of the Massachusetts Commission for the Blind, represents a substantial, but most necessary cost.

Professional and clerical staff at the state's rehabilitation agencies must increase substantially if new programs are to be implemented. But equally important, the administrative setting within which personnel will function must be organized to attract and retain qualified, capable, and willing personnel.

Major cost recommendations directed to these goals call for:

- Increasing the staff of the Massachusetts Rehabilitation Commission four-fold, from about 400 to 1600, by 1976.
- Increasing the staff of the Massachusetts Commission for the Blind from about 200 to 300, by 1976.
- Reorganizing and upgrading the top administrative positions at the Massachusetts Rebabilitation Commission and the Massachusetts Commission for the Blind.
- Revising and upgrading the position and pay classifications for rehabilitation professionals to bring Massachusetts into a competitive position with neighboring states.
- Improving the coordination and communication among state agencies and between public and private agencies through the establishment of an interdepartmental Rehabilitation Coordinating Council, a State Rehabilitation Advisory Board, Area Rehabilitation Advisory Boards, and a Rehabilitation Facilities Board.
- Broadening the preservice and inservice training of rehabilitation professionals.

A glance at Table 2 reveals that these recommendations are the most expensive among all the categories listed. Table 3 gives a brief breakdown of the approximately $16 million projected for 1976 for administrative and manpower improvements.

Table 2
PROJECTED COST OF ADMINISTRATION AND MANPOWER RECOMMENDATIONS FOR FISCAL 1971 AND 1976

Massachusetts Rehabilitation Commission and Massachusetts Commission for the Blind

Recommendation	Cost Estimate (1971)	1976
Strengthened Top Administration	$ 400,000	$ 1,100,000
Rent for Area and Central Office	100,000	200,000
Increased Staff at the Massachusetts Rehabilitation Commission	4,500,000	13,500,000
Increased Staff at the Massachusetts Commission for the Blind	330,000	1,000,000
Inservice Training	67,000	200,000
Educational Leaves	50,000	168,000
Internships and Scholarships	65,000	200,000
TOTAL	$5,512,000	$16,368,000

FINANCING CLIENT SERVICES

Financing a system of community rehabilitation services for handicapped persons involves the cost of:

- Organizing and directing programs of prevention and casefinding.
- Evaluating individuals to determine their work potential.
- Providing physical restoration services.
- Educating and training individuals for new vocational roles.
- Rendering necessary client maintenance and supportive services.
- Placing individuals in appropriate work or day activities.
- Initiating followup programs to determine the adjustment of individuals to their new life situations.

While all of the above activities are presently carried out by the state's rehabilitation agencies, the Planning Commission's recommendations call for substantial increases in the scope and organization of these direct client services. The manpower needed for a decentralized area based rehabilitation service system has been estimated above. In addition to personnel costs, the increased costs of operating new or expanded services must be considered.

Costs of operating comprehensive community rehabilitation programs in the 37 geographic service areas will depend on the need for specialized services within each area. Area rehabilitation advisory boards, in conjunction with the area and regional offices of the Massachusetts Rehabilitation Commission, will also influence decisions on priorities among services in each area. Therefore, it is not possible to predict the exact outlay for each area. However, by making certain assumptions, the aggregate cost of providing comprehensive rehabilitation services throughout the state can be estimated in the following listing by program categories.

Casefinding and Prevention

The total cost of implementing early casefinding and prevention programs for fiscal year 1976 (beginning July 1, 1975) will be approximately $465,000.

Not included in this estimate, but a major proposal of the Planning Commission is the recommendation for utilizing liaison consultants to alerting stations in the community. The principal cost of this recommendation, an estimated $1.3 million, is included in the manpower projections above.

Other recommendations on casefinding and prevention that will require significant financing are directed towards increasing the ability of personnel in particular categories of public and private agencies to recognize vocational and life activity handicaps and refer individuals to rehabilitation services. These major cost recommendations may be summarized as follows:

- $25,500 to operate a new Health Screening Procedures Committee under the Massachusetts Department of Public Health.
- $10,000 for a new Commission on School Health Examinations.
- $80,000 for additional personnel in the Bureau of Special Education, Massachusetts Department of Education, to provide inservice training concerning problems of the handicapped child to school personnel.
- $350,000 for services to be extended to chronically ill patients in state public health and mental health institutions.

These recommendations could be implemented by fiscal year 1971 if the state provides the amount estimated above. Although the cost of these proposals might be offset in part by federal funds, state action should not be delayed on these important programs if federal aid is not immediately available.

Vocational Evaluations

Keystone of the Planning Commission's recommendations on client services is the proposal that a feasible, efficient process of evaluating individuals to determine their work potential be established at the community level. The estimated operating cost of establishing sufficient interdisciplinary evaluation teams to conduct the minimum number of evaluations adjudged necessary for 1976 will be about $4,600,000.

Annual operating cost of preliminary and comprehensive disability assessments and vocational evaluations may be determined by estimating the salaries of the members of the proposed interdisciplinary evaluation teams. A basic three member team for each of the three major categories of disability is the basis of cost projections:

- For physically disabled persons — 37 teams of a physician, a social worker, and a rehabilitation counselor to conduct 500 evaluations per year in each of the areas, at an annual cost of $1,660,000.
- For mentally disabled persons — 37 teams of a psychologist or psychiatrist, a social worker, and a rehabilitation counselor to conduct 500 evaluations per year in each of the areas, at an annual cost of $1,290,000.
- For socially disadvantaged persons — 37 teams of a physician or psychologist, a social worker, and a rehabilitation counselor to conduct 500 evaluations per year in each of the areas, at an annual cost of $1,660,000.

Projections for vocational evaluations do not include the cost for rehabilitation counselors whose salaries are included in manpower projections. Nor do they include the cost of inpatient facilities related to evaluations or costs for overhead. However, the financing of overhead expenditures will be assumed in part by the hospitals, clinics and workshops that function as evaluation centers, and offset in part by third party payments such as health insurance, welfare, medicaid, and workmen's compensation.

Physical Restoration Services

A significant proportion of funds expended for direct client services in rehabilitation is spent on medical and therapeutic services, drugs, and prosthetic devices essential to obtaining employment. The Planning Commission was not able to obtain detailed statistics on the various categories of physical restoration services within the rehabilitation program in Massachusetts. Consequently, a firm basis for projecting expenditures was not possible.

Aggregate figures for physical restoration services by the state's rehabilitation agencies were obtained. Thus, it was possible to determine the proportion of total rehabilitation expenditures represented by restoration services, and project expenditures into the future. Using this method, the estimated cost of physical restoration services for 1976 will be approximately $2,540,000. Physical restoration services will be financed under the federal-state rehabilitation program with the federal share at 80%, the state share at 20%.

Education and Training Services

Projecting the cost of education and training services presented similar problems to those encountered with physical restoration services. Detailed breakdowns of current expenditures for educational services to handicapped persons were not available. This prevented firm projections of future educational expenditures by disability classifications and educational alternatives.

Aggregate agency expenditures on educational services were available. Therefore, the proportion of current total rehabilitation expenditures represented by educational services was calculated. Based on the 1968 ratios, educational services for 1976 were projected at approximately $9,000,000.

Sheltered Workshops

Not included in the above estimates for education and training are the costs of implementing the recommendations on sheltered workshops as a training and placement resource. The Planning Commission recommends that at least

one comprehensive sheltered workshop be designated in each rehabilitation service area by the Rehabilitation Facilities Board. Other recommendations of significant cost, include proposals to establish and upgrade workshops in institutions and to provide day care programs under the auspices of area workshops for those individuals who could benefit from supervised social activities.

Projected costs of these proposals would be:

- $13.0 million for annual operating expenses of 50 area workshops (including operation of day care programs).
- $1.0 million for annual operating expenses of workshops in appropriate mental health, correctional and public health institutions.
- $107,000 for additional full time personnel in the Departments of Public Health and Corrections to supervise and plan workshop development.

At least 50% of the estimated $14.3 million projected for workshop development will be offset by federal aid. A relatively high share of state monies is required for state workshop services because it is anticipated that a significant proportion of the clientele will be in extended sheltered employment and will not be receiving day activity services. Operating costs for these programs are not currently funded under provisions of the Vocational Rehabilitation Act. Wage supplements for workshop employees earning below the minimum wage are recommended by the Planning Commission, although estimates of this expenditure could not be projected at this time.

Supportive Services

Supportive services such as counseling, homemaking, transportation, and assistance with housing problems should be available to handicapped persons during rehabilitation and thereafter as needed. Some individuals may also need money to purchase food, clothing, and other necessities to maintain themselves during the rehabilitation process. These supportive services should be an integral part of a comprehensive community rehabilitation program.

Detailed information on the present spending for various types of services needed to maintain individuals during rehabilitation was available only in total, not broken down by specific services. Therefore, firm projections could not be made of future expenditures on the basis of individual items of service.

Utilizing the aggregate agency expenditure for client maintenance services, it was possible to project future expenditures in proportion to future client levels. For 1976, a minimum level of client maintenance costs was projected at $2.5 million.

New supportive programs advanced by the Planning Commission, may be expected to cost as follows, in 1976:

- A minimal program of homebound employment in each of the 37 areas will have an annual operating cost of about $825,000.
- New supportive services to be developed at the area level, such as homemaking, personal counseling, and meals-on-wheels, will have an annual cost of about $5.1 million.
- Reimbursement to private agencies for the cost of operating a minimal program for transporting handicapped persons to services they could not otherwise utilize will cost about $1.8 million annually.

The total cost in 1976 of client maintenance and supportive services is estimated to be $10,325,000.

Placement and Followup

Projected cost of implementing the Planning Commission's recommendations on placement and followup services is $858,000. The primary components of placement and followup costs are increased manpower, training programs, and programs directed toward increased public and professional awareness of the placement problems of handicapped persons.

Manpower for increased placement assistance at mental health-retardation centers and area offices of the Massachusetts Rehabilitation Commission are not included in these estimates. The proposed staffing of area rehabilitation services includes recognition of these tasks.

Most of the recommendations on placement and followup are for programs which will be funded with federal assistance. Proposals calling for new placement programs under the Massachusetts Commission on Employment of the Handicapped ($100,000), and the Division of Employment Security ($207,000) would be the responsibility of the Commonwealth.

SPECIAL PROBLEMS

Architectural Barriers

Most of the recommendations of the Planning Commission related to architecturai barriers imply a cost. But, in nearly all cases, the cost is an indirect one to be assumed by developers, business and governments in designing and constructing buildings. The General Services Administration of the United States Government estimates that the cost of designing and constructing barrier free buildings is 1% less than of total building costs.

Specific proposals to increase the staff of the state architectural barrier board, to establish an office for handicapped students at the University of Massachusetts at Boston, and to undertake a study of barriers in Massachusetts transportation were estimated as follows:

- Increased staff for the architectural barriers board, including a full time executive secretary and clerical and technical staff is estimated at $20,000 annually.
- An office for handicapped students at the University of Massachusetts at Boston could be staffed by a director-counselor, assistant director-counselor, and a secretary, and equipped with necessary student aid equipment for approximately $53,000 annually.

- A transportation study, modeled after a current national study by ABT Associates of Cambridge, Massachusetts, could be undertaken for about $100,000.

In addition to these proposals, which have been included in the total estimates presented in Table 2, the recommendation to establish special barrier free housing in the state's metropolitan areas will involve significant costs.

A present apartment house being constructed in Fall River with the barrier free and supportive services recommended by the Planning Commission will cost $2,700,000 ($13,390 per unit; 209 units). If one such facility were to be constructed in each of the Commonwealth's ten metropolitan areas, the cost would be $27,000,000. More than one facility would be required in the larger metropolitan areas raising this cost even higher.

Through the federal housing programs, substantial assistance is available for such projects. In addition, the feasibility and operational costs of such units is currently being studied. For these reasons, this recommendation remains at present a highly desirable goal, the total cost of which cannot be projected.

Public Offender

Total cost of implementing the recommendations of the Planning Commission for rehabilitating the public offender will be about $2.9 million. Primary components of these annual operating costs will be increased manpower, and the cost of evaluation, restoration and training-placement services:

- Evaluations for all prisoners sentenced to six months or more by the interdisciplinary team of a physician-psychiatrists, social worker and rehabilitation counselor would cost $720,000 annually (16 teams).
- Prevocational services such as personal adjustment training classes would cost $460,000 (51 classes).
- Restoration services for public offenders may be projected at an annual expense of about $560,000 (based on Department of Correction statistics of prisoners found to have physical or mental handicaps).
- Prerelease, release, and training programs may be projected at approximately $950,000. (Based on 15% of prison population participating in work release, and 10 halfway houses with 20 persons per house).

Multiple funding sources may be available to pay for these programs. Recent federal Vocational Rehabilitation Amendments have extended eligibility to public offenders, and the above proposals will allow the Commonwealth to share in these newly available funds.

Rehabilitation Research

Implementation of the Planning Commission's proposals for improving rehabilitation research will cost approximately $658,000 per year by fiscal year 1976. The anticipated cost of a minimal program to be in operation for fiscal year 1971 will be about $450,000.

These estimates are primarily based on the cost of operating new programs for training individuals to participate in rehabilitation research, and for improving coordination and communication among researchers. Consequently, nearly half of the total estimated operating expenditures for 1976 ($323,000) are for recommendations directed to private or autonomous public organizations such as colleges, universities, and professional associations:

- $141,000 to operate an interuniversity postdoctoral research training program.
- $145,000 to operate master's degree programs for training research specialists in the medical, social and biological sciences.
- $16,000 to operate a minimum of eight programs to train research technicians at community and junior colleges.
- $14,000 to conduct annual conferences in each of the seven rehabilitation regions as a means of continuing education in rehabilitation research.
- $7,000 for four conferences annually to promote interuniversity communication among rehabilitation scholars and investigate the establishment of a *Journal of Rehabilitation Research*.

The remaining $335,000 projected cost of implementing the Planning Commission's research proposals would be borne by the federal government. This amount includes an estimate of $300,000 to initiate a program of rehabilitation career fellows and to establish a program of research consultation under the Regional Rehabilitation Institute, Northeastern University.

Technological Change

The projected annual operating cost of a manpower policy and development unit within the State Executive Office of Administration and Finance comprises the only expenditure among the proposals of the Planning Commission related to technological change and occupational patterns. Annual operating expenses of the proposed unit will be $110,000. Most of this amount will be for increased personnel to staff and work with the unit.

Implementation of this proposal has already begun. Budget estimates of the Executive Office of Administration and Finance for fiscal year 1970 include requests for manpower planning personnel. Future costs of this unit may be offset in part by federal assistance.

Appendix 1
BACKGROUND AND PROCEDURES

Since its inception in 1921, the federal-state vocational rehabilitation program has been characterized by continuous expansion in services provided to handicapped persons, in broader disability categories, and in the technical capabilities of professional rehabilitation workers. What originated as a very limited program for the physically disabled grew into a more comprehensive program of services to handicapped persons through a variety of public, voluntary and private agencies and practitioners.

In recognition of the growth and complexity of rehabilitation services and in support of the states as the primary level for the delivery of services, the 1965 amendments to the Vocational Rehabilitation Act included a provision for comprehensive statewide planning efforts which would assess the needs and plan for the orderly development of services for all handicapped persons by fiscal year 1976.

PLANNING ORGANIZATION

The Vocational Rehabilitation Planning Commission, composed of 45 persons representing the state legislature, state human service agencies, organized labor, management, health and welfare organizations, universities and professional organizations, was appointed by Governor John A. Volpe on May 4, 1965, under Executive Order No. 50. W. Scott Allan was appointed Planning Commission Chairman by the Governor. Mr. Allan, a member of the National Citizens' Advisory Committee on Vocational Rehabilitation, was president of the National Rehabilitation Association in 1965-66.

The Governor gave the Planning Commission the responsibility to make rules and regulations for its organization, apply for and receive a statewide planning grant for vocational rehabilitation services, contract for consulting services for the planning project, supervise and administer the project, call on all state agencies and officials for cooperation and assistance, appoint experts to assist and advise the project, and submit the final report of the Planning Commission to the Governor by October 1968.

Within the Planning Commission an Executive Committee of eight members, chaired by the Planning Commission Chairman, was appointed. The Executive Committee met more frequently than the entire Planning Commission, initiated special meetings of the Planning Commission and, working closely with the Executive Director, brought to the Planning Commission matters of policy and implementation requiring approval from that body

All recommendations proposed by task forces and by the staff were reviewed by the entire Planning Commission and changed, amended, or rejected. On occasion, the Planning Commission initiated its own proposals. The final report presented to the Governor is the report of the Planning Commission.

The Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind were repesented on the Planning Commission by the Commissioner of Rehabilitation and the Commissioner for the Blind. Key staff members of the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind were designated to work closely with the planning staff. Close liaison was maintained with Massachusetts Rehabilitation Commission staff conducting the statewide survey of facilities and workshops.

The Planning Commission contracted with The Medical Foundation, Inc., of Boston, a voluntary health organization, to provide professional counsulting staff and office space. An executive director was appointed to coordinate the activities of the consulting staff and the Planning Commission.

TASK FORCES

Generally, the scope of the Planning Commission's planning activities extended from the prevention of the onset of disability to extended care for those with chronic disabilities; from concern about populations with traditionally defined physical and mental disabilities to concern about those who will become functionally disabled because of future technological changes and dislocations in the labor market; from specific proposals for improving state agency procedures to a consideration of a broad network approach for the delivery of rehabilitation and associated health and welfare services.

Ten task forces were created to discuss major rehabilitation issues and produce a report and recommendations. Task forces were grouped into three major categories: generic, specialized and resources.

Generic task forces considered prevention and early case-finding, vocational evaluation and training, and placement and followup. Attempting to cut across disabilities, these task forces covered the full spectrum of techniques and procedures for prevention as well as for assisting and rehabilitating handicapped persons.

Specialized task forces considered the problems of architectural barriers, rehabilitating the public offender, and technological change and occupational patterns. The rationale for developing specialized task forces was derived from a determination of the urgency or past gaps in the consideration of particular crucial substantive areas.

Resource task forces were convened during the second year of the Planning Commission. On the basis of information fed to them by first year task forces, public hearings and surveys, these groups considered specific problems in administration, professional training and manpower, community services, and research.

Initially, much time was devoted to carefully selecting task force participants, developing guidelines for task force action and through orientation of chairmen and staff. Key

administrators in rehabilitation programs, professional researchers in several related fields, consumers of services, and spokesmen for consumers and lay organization leaders participated in task force deliberations.

All task forces had three distinct functions irrespective of the substantive areas covered. First, to gather expert opinion and information which formed the substance of a report and recommendations. Second, to provide an arena whereby the various interests and, in some instances, the circumscribed perspective of the specialist, might be broadened to consider central patterns and concerns. Third, to build support, commitment, and leadership for the eventual conclusions and recommendations of the entire Planning Commission. By providing open arenas for focused deliberations, the task forces proved to be an effective and efficient means to produce a balanced approach to complex and multifaceted problems.

DATA GATHERING ACTIVITIES

An extrapolation of projected numbers of disabled residing in Massachusetts, based on census data, National Health Survey data, and town and city monographs, was organized by the 37 geographic service areas which will be used by the public mental health-retardation, welfare and rehabilitation programs, in addition to other state programs, as uniform service jurisdictions.

The Planning Commission surveyed a large number of agencies and professionals who acted either as points for identifying problems faced by disabled persons and/or suggested vehicles for providing services to the disabled. These resource groups included all rehabilitation units of hospitals in the Commonwealth (physical therapy, physical medicine, occupational therapy, social services and rehabilitation); all workshops and activity centers; the state's mental health clinics; private family service agencies; boards of health and visiting nurse associations; public school systems; local welfare units; and representative samples of the clergy and physicians. In addition, the Planning Commission gathered information from programs of the United States Department of Labor, the Office of Education, the Office of Economic Opportunity and other federal and state programs for the vocationally handicapped.

The Planning Commission used these data to develop a ranking of the 37 geographic service areas in terms of available resources and the relative population needs for services in different parts of the state.

A major focus of this data gathering was the handicapped citizen himself. Through direct contact with Massachusetts self-help groups, including the Massachusetts Association of Paraplegics, the Associated Blind of Massachusetts, United Cerebral Palsy, and Cured Cancer, the Planning Commission collected a large number of essentially biographical questionnaires describing the perception of barriers to effective services which the disabled individual himself felt to be most pressing.

Staff studies also included a compilation of law, regulations, administrative organization, services and interorganizational relationships of major state agencies. Included were the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Departments of Mental Health, Public Health, Public Welfare, Corrections, and Education, the Industrial Accident Board, Probation, Parole and selected manpower programs emanating from the Division of Employment Security and other agencies.

PUBLIC HEARINGS

Public hearings held in Boston, Lowell, New Bedford, Worcester, Springfield and Pittsfield were a key community relations and public information activity. More than 200 persons testified. The purposes of these hearings were to feed data into the decision making machinery of the project and to increase local support for key Planning Commission recommendations. Important local information was gathered by people working and living in the community and familiar with the unique problems of their area. All hearings were chaired by W. Scott Allan, Chairman of the Planning Commission, and received excellent local press coverage as well as frequent attention from local television and radio. More than 30 members of the Planning Commission sat as panelists at the hearings.

As expected, the testimony varied greatly both in the scope of the subject and the quality of presentation, but keen community interest and awareness of needs were consistently apparent.

Recurring themes throughout the hearings included appeals for:

- Improved coordination of services and responsive service delivery and referrals.
- Shortened waiting periods for determination of eligibility by the public rehabilitation program.
- Information about where people not eligible for the federal vocational rehabilitation program can go.
- Upgrading personnel providing rehabilitation services.
- Expanded supportive services, including housing and transportation.
- Elimination of architectural barriers in schools, other public buildings and residences.
- Multidisability sheltered workshops.

Governor Volpe, addressing the public hearing in Boston noted, "Vocational rehabilitation planning comes at a time of much ferment and considerable action in finding better ways to serve our citizens . . . An important purpose of all these activities and others begun under this administration is to answer that essential services undertaken by the government are provided comprehensively, efficiently and effectively . . . We look upon your planning to provide us with specific approaches which might be used as models in our search for better ways to integrate and coordinate our many human services . . . our goal and yours is to rehabilitate, to make more productive and independent, people who carry the daily yoke of a physical or mental handicap."

LINKS TO OTHER STATEWIDE PLANNING

Fortunately, the Planning Commission was able to maintain close ties with the recent statewide comprehensive planning efforts in mental health and mental retardation. The Medical Foundation, the Planning Commission's designated study and planning organization, completed statewide mental health planning in 1965 and mental retardation planning in 1966. A number of staff members who worked on the mental health and mental retardation planning projects were also closely affiliated with the vocational rehabilitation planning effort.

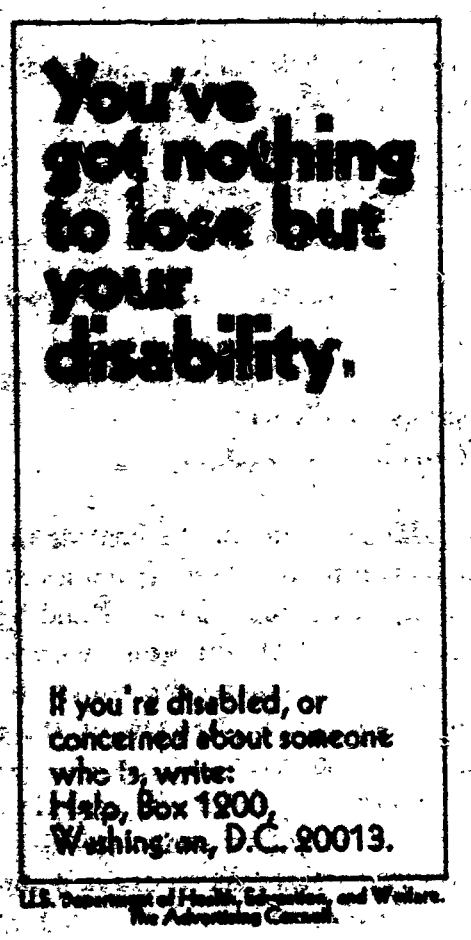
A staff liaison arrangement was instituted with the Massachusetts Rehabilitation Commission and the Commission for the Blind for the cooperative development and sponsorship of the workshop questionnaire and an open exchange of findings from other surveys prepared by the Planning Commission and the state Workshop and Facilities Planning Unit.

Close coordination was maintained with comprehensive health planning staff in the Executive Office of Administration and Finance. Additionally, close correlation of findings and recommendations were assured with the long range planning activities of the Office of Planning and Program Coordination within the Executive Office of Administration and Finance.

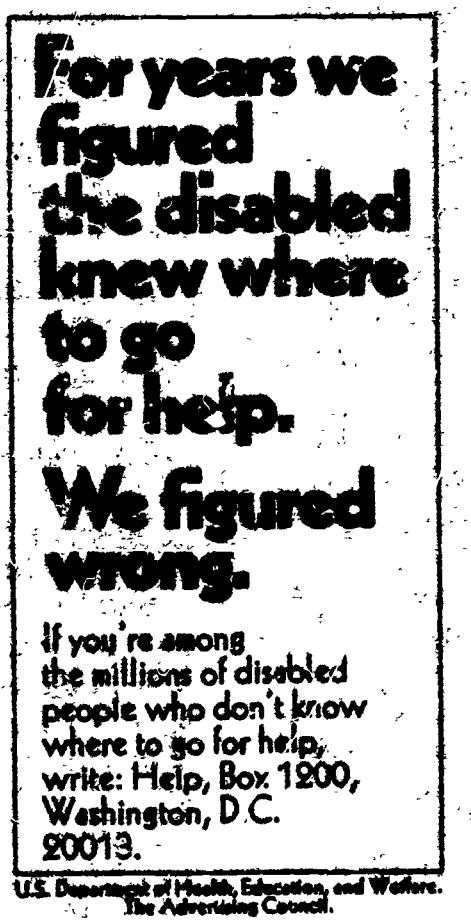
A FOOTNOTE ON IMPLEMENTATION

Expectations of those concerned with helping the handicapped through support of the Planning Commission's recommendations were aptly expressed in a recent newsletter distributed by a self-help group, the Massachusetts Association of Paraplegics:

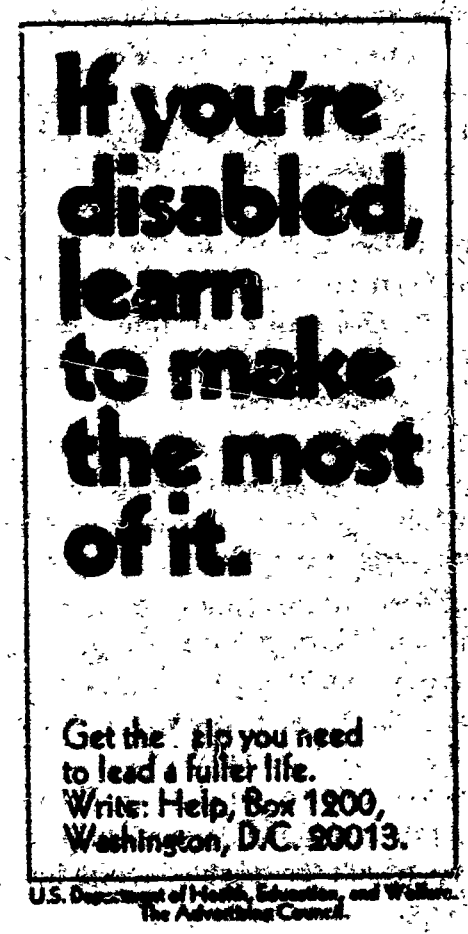
> "The establishment of task forces (whose members included representatives of all interested groups including the handicapped) designed to study specific problems has resulted in much creative thought on lessening or eliminating the problems with which we are concerned.
>
> . . . The Planning Commission has, at one time or another during its tenure, considered virtually all of the problem areas which we have been able to define (as well as some which we never considered).
>
> . . . Of course, it is probably true that a good many study commissions have achieved similar results and yet failed because the legislature did not act positively on their recommendations. And, this may well happen again if we sit aside and do nothing.
>
> . . . However, if we are to do something positive regarding the Planning Commission proposals, *WE MUST START NOW* to chart the best course of action".



AD MAT NO. REH-106-69
50 LINES (1 col. x 3½")



AD MAT NO. REH-107-69
50 LINES (1 col. x 3½")



AD MAT NO. REH-108-69
50 LINES (1 col. x 3½")

Appendix 2
RANKING OF GEOGRAPHIC SERVICE AREAS BY ESTIMATED NUMBER OF DISABLED. NONINSTITUTIONALIZED PERSONS UNDER 65 YEARS OF AGE

GEOGRAPHIC SERVICE AREAS	*ESTIMATED NUMBER OF DISABLED PERSONS*			*TOTAL*	*RANK*[3]
	Extrapolation from The National Health Survey of Physically and Emotionally Disabled Persons Between 5 and 64	*Retarded Students in Special Classes*	*Estimated*[2] *Number of Non Special Class Retardates*		
Barnstable	3,105	231	330	3,666	29
Berkshire	3,842	264	412	4,518	23
Boston:					
Brookline-Brighton	8,558	712[1]	908	10,178	4
Government Center	7,287	602[1]	768	8,607	8
Roslindale	8,634	702[1]	916	10,252	3
Roxbury-Dorchester	5,787	482[1]	614	6,883	12
South Boston	2,813	234[1]	300	3,347	31.5
Brockton	5,469	509	580	6,558	15
Cambridge	7,767	196	820	8,783	6
Concord	1,517	106	160	1,783	37
Danvers	7,653	291	812	8,756	7
Fall River	5,142	320	546	6,008	16
Fitchburg	4,759	374	510	5,643	21
Foxborough	2,396	150	254	2,800	36
Franklin-Hampshire	3,846	144	408	4,398	25
Gardner	2,599	200	276	3,075	34
Grafton	3,647	340	386	4,373	26
Haverhill	3,440	335	364	4,139	28
Holyoke	6,080	489	644	7,213	11
Lawrence	2,817	232	298	3,347	31.5
Lowell	6,214	355	658	7,227	10
Lynn	5,364	25	568	5,957	18
Malden	6,502	288	690	7,480	9
Medfield	5,089	299	540	5,928	20
Mystic	5,187	257	550	5,994	17
New Bedford	5,614	584	596	6,794	13
Newton	5,176	229	548	5,953	19
Plymouth	2,394	252	254	2,900	35
Quincy	9,324	620	988	10,932	2
Reading	3,660	198	388	4,246	27
Southbridge	3,780	322	400	4,502	24
Springfield	7,578	696	840	9,114	5
Taunton	2,926	227	312	3,465	30
Waltham	4,817	251	510	5,578	22
Westborough	5,704	411	604	6,719	14
Westfield	2,799	272	296	3,367	33
Worcester	9,406	554	998	10,958	1
TOTAL	188,642	12,783	20,050	221,441	

[1] The 2,733 special class students in Greater Boston (Bureau of Special Education, Massachusetts Department of Education, June 1968) were assumed to be geographically distributed among the 5 geographic service areas comprising Greater Boston in similar proportions to the physically and emotionally disabled persons extrapolated from the National Health Survey.

[2] The 20,000 non special class retardates estimated by the Massachusetts Department of Mental Health to be living at home and to be requiring services which are not presently being provided were assumed to be distributed among the 37 geographic service areas in similar proportions to the distribution of physically and emotionally disabled persons extrapolated from the National Health Survey.

[3] Areas are ranked from 1 to 37, indicating highest to lowest number of disabled persons. Where two areas have the same number of disabled persons, a tied rank is indicated.

Appendix 3
RATIONALE FOR RANKING GEOGRAPHIC SERVICE AREAS BY NUMBERS OF DISABLED PERSONS LIVING AT HOME FOR MASSACHUSETTS

EXTRAPOLATION FROM THE NATIONAL HEALTH SURVEY

Estimates of disability in this report were obtained from National Health Survey data and 1960 census tabulations for Massachusetts. The National Health survey collects a wide variety of health related data from a continuing nationwide sample survey of households. The estimates in this report are based on the combined prevalence of persons unable to carry on major activity for their group and persons limited in the amount or kind of major activity performed (major activity refers to ability to work, keep house or go to school.[1]

Special tabulations for the Northeast region (includes New England and Middle Atlantic states) for 1964-65 were run by the National Center for Health Statistics. For each of 16 sex, race and age cross-classifications prevalence rates for the combination of the two categories of disability were calculated. These are shown in Table 1 and form the basis for the estimates present in this report.

The estimates were generated by applying the rates for white males and white females to 1960 census tabulations of the Massachusetts population by sex, age and minor civil divisions.[2] There are two slight inconsistencies in applying these rates. First the disability rates for the white categories are applied to population categories for whites and nonwhites combined. Since the rates in Table 1 indicate that nonwhite are higher than white rates for each category except males age 17-44, the effect is a conservative estimate, i.e., an underestimate. Since nonwhites in Massachusetts comprise a relatively small proportion of the total population (2.4% according to the 1960 census[2]), this error is slight. Second, census tabulations yield age categories <15 and 15-44 whereas the rates in Table 1 are for ages <17 and 17-44. Since the <17 rates are lower than those 17-44, the net result in applying these rates to the population categories is a very slight overestimate. Of course, it cannot be assumed that these two errors are self-cancelling. It is evident, however, that their net effect is, for all practical purposes, negligible.

A more important basis for considering these estimates as being conservative is that 1960 census data have been used whereas there has been population increase since then. The total population of Massachusetts is estimated to increase 6.3% between 1960 and 1970.[3] The estimated 1960 to 1970 percentage increases by age and sex for Massachusetts are shown in Table 2. Applying the rates in Table 1 to the 1960 census figures and the 1970 projected population estimates the total number of disabled is estimated to increase 9.4% over the decade. This calculation assumes, of course, that the prevalence rates in Table 1 are applicable to Massachusetts and remain constant over time. With regard to the latter assumption, it has been reported that the estimated rates of disability for the entire United States remain relatively stable over time.[4]

Methodologically, it would seem desirable to obtain National Health Survey prevalence figures specifically for Massachusetts and with further cross-classification on important variables related to disability (e.g. income, urban-rural residence, family size, occupation). First, the sample size of the National Health survey precludes the attainment of reliable estimates of rates on a statewide basis. Second, even with regional estimates, cross-classification on more than two or three variables leads to doubtful reliability. A further difficulty with cross-classification is that the corresponding cross-classification of the 1960 census data must be available. Unfortunately, for minor civil divisions (which form the basic units from which the estimates in this report are constructed) such tabulations do not exist.

Recently, estimates of disability state by state have been calculated for 1962-1964.[4] The methodology is somewhat more complex although analogous to that used here. The estimated prevalences of disability includes a third category, "Persons not limited in major activity but otherwise limited."It is interesting to note that Massachusetts is estimated to have the third lowest prevalence rate of disability in the country, 9.8%. Only Connecticut and New Jersey have lower estimated rates. 9.2% and 9.4% respectively.

In conclusion it must be emphasized that the estimates in this report are based on the key assumption that the prevalence rates in Table 1 for the Northeast region apply to the minor civil divisions in Massachusetts. It is not possible to test the validity of this assumption. However, lacking survey data specifically for Massachusetts, the estimates presented in this report appear to be about the best one can achieve with the limited information that is available.

Table 1

PREVALENCE OF PERSONS WITH LIMITATION IN AMOUNT OR KIND OR UNABLE TO CARRY ON MAJOR ACTIVITY BY SEX, RACE AND AGE, NORTHEAST REGION, 1964-1966

Age	*White males*	*Nonwhite males*	*White females*	*Nonwhite females*
<17	.0085	.0178	.0073	.0151
17-44	.0357	.0323	.0358	.0596
45-64	.1108	.1365	.0964	.1639
65+	.3813	.4484	.3302	.3547

Table 2

ESTIMATED PERCENTAGE INCREASE OF MASSACHUSETTS POPULATION BETWEEN 1960 AND 1970 BY SEX AND AGE

Age (yrs.)	*Males*	*Females*
<15	2.0	1.8
15-44	9.9	4.9
45-64	7.9	6.8
65+	6.1	16.1

PREVALANCE RATES FOR THE RETARDED

The National Health Survey includes all forms of disability, physical and emotional, with the exception of mental retardation. For this reason, it was necessary to add figures for the retarded to our statewide prevelance table, in order to present a fuller picture of the Massachusetts disability picture.

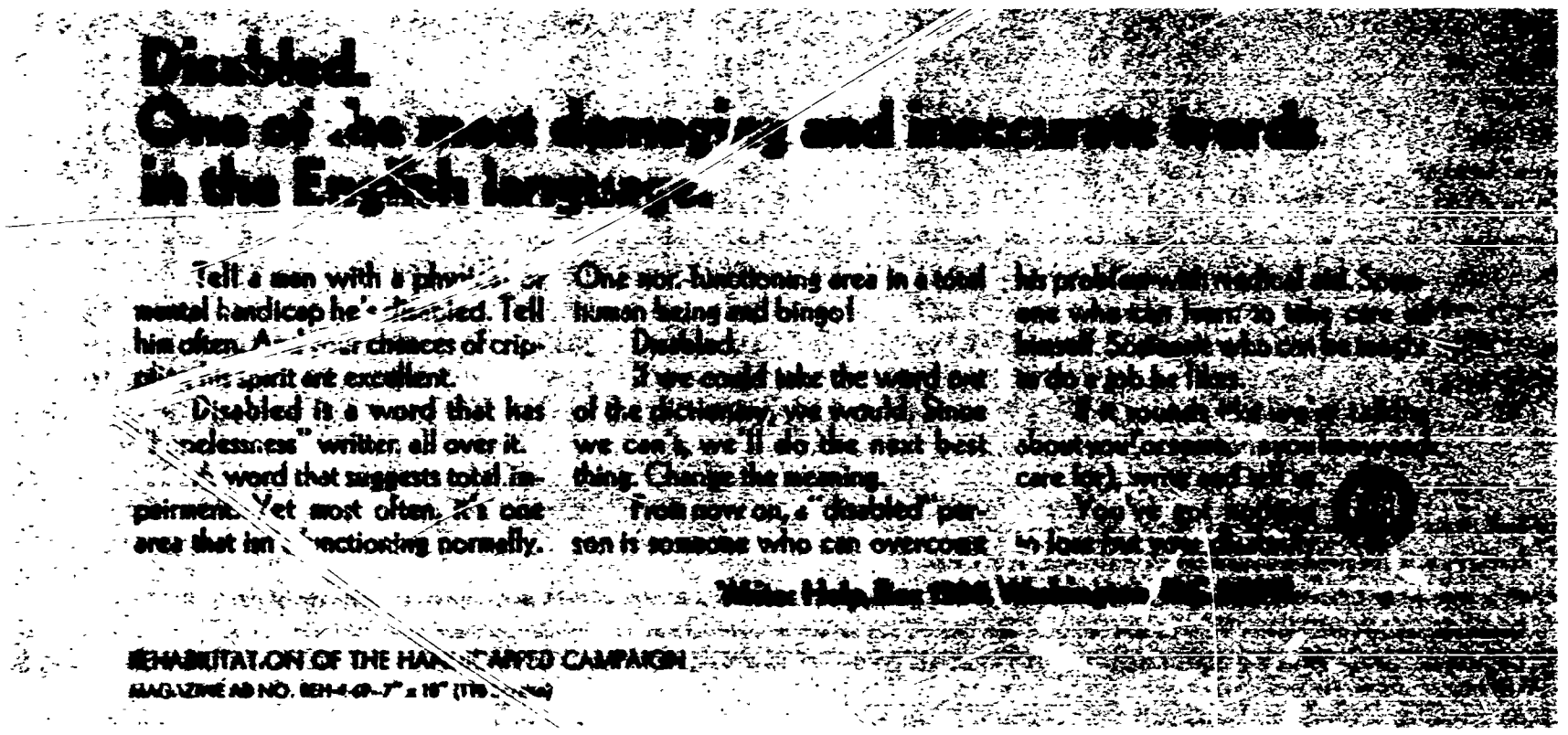
Towards this end, two additional types of data are included. Each city and town in the Commonwealth provides a census of the number of school children in special classes for the retarded. This data was collected and organized by catchment area, on the assumption that all such children are indeed a legitimate segment of the "population at risk." Secondly, the most recent estimate obtained from the office of Assis . ' Commissioner for Mental Retardation, Massachusetts Department of Mental Health is that there are 20,000 retarded citizens living in the community who require services but are presently receiving no services. This group was also included in the risk population figures and was weighted among the catchment areas on a proportionate basis to the percentage of physically and emotionally disabled in each area.

POPULATION OVER 65

These figures do not reflect the expected population of over 130,000 citizens of the Commonwealth over 65 years of age who would be classified as disabled by the criteria of the National Health Survey. While it is recognized that this large population has many significant needs of a rehabilitation nature to be met, their age clearly precludes them from the major job markets. In addition, limited resources suggest a need for priorities in the development of rehabilitation services, such that it appears feasible to concentrate efforts on the population under 65 for at least the forseeable future.

REFERENCES

1. National Center for Health Statistics, "Chronic Conditions and Activity Limitation" Series 10, Number 17, U.S. Dept. of Health, Education, and Welfare, Washington, D.C. 1965.
2. U.S. Bureau of the Census, "U.S. Census of Population: 1960. General Population Characteristics, Massachusetts." Final Report PC(1)-23 B, U.S. Dept. of Commerce, Washington, D.C., 1961.
3. Executive Office for Administration & Finance, "Massachusetts Population Projections to 1975" Program Planning & Research, 1967.
4. National Center for Health Statistics "Synthetic State Estimates of Disability Derived from the National Health Survey", U.S. Dept. of Health, Education, and Welfare, Washington, D.C., 1968.



Appendix 4

GEOGRAPHIC SERVICE AREAS BY SOCIOECONOMIC NEED FACTORS AND RANKED BY SOCIOECONOMIC NEED

Geographic Service Area	*Factors Defining Socioeconomic Need*			*Ranking of Areas[4] By Each Socioeconomic Need Factor*			*Ranking of Areas[5] By Total Socio-economic Need*
	Family Income Less than $3000[1]	*Less than 5 Yrs. Education[2]*	*AFDC Recipients[3]*	*Family Income Less than $3000*	*Less than 5 Yrs. Education*	*AFDC Recipients*	
Barnstable	18.8	3,427	1,066	3	32	14	16.5
Berkshire	13.7	5,025	1,083	12	23	13	14.5
Boston:							
Brookline-Brighton	13.0	3,931	2,755	16	30	3	16.5
GovernmentCenter	17.0	11,110	1,595	6	3	6	4
Roslindale	10.4	6,610	2,200	25	8	4	9
Roxbury-Dorchester	26.6	8,838	5,465	1	4	1	1
SouthBoston	18.4	8,619	4,258	4.5	5	2	3
Brockton	10.5	4,512	942	23.5	29	17	26.5
Cambridge	12.2	6,012	1,466	19	15	9	11
Concord	7.2	3,663	770	33	31	21	30
Danvers	11.4	4,634	777	22	27	20	25
FallRiver	18.4	11,627	1,348	4.5	2	10	5
Fitchburg	13.2	5,219	719	15	21	25	23
Foxborough	8.8	3,367	537	28	33	29	31
Franklin-Hampshire	15.8	5,926	735	7	17	23	12.5
Gardner	14.3	6,440	668	10	11	26	12.5
Grafton	10.5	5,834	538	23.5	18	28	26.5
Haverhill	13.6	4,937	1,014	13.5	24	15	18
Holyoke	11.8	6,554	581	20	9	27	21
Lawrence	15.1	8,601	768	8	6	22	8
Lowell	9.0	4,892	955	27	25	16	24
Lynn	12.4	4,876	1,343	18	26	11	19.5
Malden	10.0	6,060	1,574	26	14	8	14.5
Medfield	6.4	5,314	172	35	20	36	32
MysticValley	6.3	2,589	288	36	36	35	36.5
NewBedford	20.4	12,728	1,764	2	1	5	2
Newton	5.8	2,131	118	37	35	37	36.5
Plymouth	12.5	5,051	841	17	22	19	22
Quincy	7.8	6,003	521	30.5	16	30	28
Reading	7.1	1,872	332	34	37	32	35
Southbridge	11.7	6,507	723	21	10	24	19.5
Springfield	14.1	6,331	1,579	11	12	7	6
Taunton	14.4	6,637	884	9	7	18	7
Waltham	7.7	4,521	461	32	28	32	33
Westborough	7.8	3,027	391	30.5	34	34	34
Westfield	8.5	5,382	410	29	19	33	29
Worcester	13.6	6,122	1,264	13.5	13	12	10

1 Percentage of families (Source : 1960 Census)

2 Rate per hundred thousand people over 25 (Source: 1960 Census)

3 Rate per hundred thousand general population (Source: 1960 Census and October 1963 Report of the Massachusetts Department of Public Welfare)

4 Deteriorating and delapidated housing was not used as a factor since sufficient material was not available to make such use meaningful.

5 Geographic service areas are ranked from 1 to 37 to indicate greatest to least socioeconomic need Where areas have equal need, this is represented by tied ranks

Appendix 5
THE DISTRIBUTION OF HOSPITALS[1] AMONG GEOGRAPHIC SERVICE AREAS RATED BY COMPREHENSIVENESS OF MEDICAL REHABILITATION SERVICE[2] OFERED WITHIN EACH HOSPITAL

Scope of Medical - Rehabilitation Services

Geographic Service Area	*Comprenensive*[3]	*Rehabilitation*[4]	*Physical therapy Occupat'l therapy and Social Services*	*Physical therapy and Occupat'l therapy*	*Physical or Occupat'l Therapy And Social Services*	*Physical or Occupat'l Therapy*	*Social Services*
Barnstable			Cape Cod, (Hyannis)				Falmouth Martha's Vineyard, Oak Bluffs Nantucket Cottage
Berkshire	Berkshire Rehabilitation Center, (Pittsfield)		St. Luke's (Pittsfield) Hillcrest, Pittsfield Fairview, Gt. Barrington			North Adams Plunkett Memorial, Adams	
Boston: Brookline-Brighton	Beth Israel Lemuel Shattuck, Jamaica Plain Kennedy Memorial, Brighton	Jewish Memorial Roxbury	Robert Bent Brigham, Roxbury		Washingtonion, Jamaica Plain Peter Bent Brigham, Roxbury St. Elizabeth's Brighton Children's Medical Center Faulkner, Jamaica Plain		New Engla. d Deaconness New England Baptist, Roxbury
Government Center	Massachusetts General					Grover Manor, Revere Revere Memorial	Mass. Eye and Ear
Roslindale		Mattapan Chronic Disease Hebrew Rehabilitation Center, Roslindale			Carney, Dorchester		
Roxbury-North Dorchester	Boston University General				New England, Roxbury Boston City		
South Boston	Rehabilitation Institute		Long Island, Boston				
Cambridge	Holy Ghost, Cambridge				Mt. Auburn, Cambridge	Somerville Central, Somerville Sancta Maria, Cambridge	
Concord						Emerson, Concord Valleyhead, Carlisle	
Danvers			Beverly		Salem Thomas, Peabody	Hunt Memorial, Danvers Gilbert, Gloucester	
Fall River			Hussey, Fall River Fall River Rehabilitation Center		Union, Fall River Truesdale, Fall River		
Fitchburg			Burbank, Fitchburg Nashoba Community Ayer			Leominster	
Foxborough						Sturdy Memorial Attleboro	
Franklin-Hampshire			Franklin County Public Health, Greenfield			Farren Memorial, Montague Cooley-Dickinson, Northampion	

Appendix 5 (Continued)

Scope of Medical - Rehabilitation Services

Geographic Service Area	*Comprehensive*[3]	*Rehabilitation*[4]	*Physical therapy Occupat'l therapy and Social Services*	*Physical therapy and Occupat'l therapy*	*Physical or Occupat'l Therapy And Social Services*	*Physical or Occupat'l Therapy*	*Social Services*
Gardner		Rutland Heights	Heywood Memorial, Gardner				
Grafton			NONE				
Haverhill						Amesbury	Haverhill Municipal
Holyoke					Providence, Holyoke	Holyoke	
Lawrence		Bon Secours, Methuen			Lawrence General		
Lowell		St. Joseph's, Lowell			Tewksbury Lowell General St. John's, Lowell		
Lynn		Lynn			Union, Lynn Saugus General		
Malden					Malden	Lawrence Memorial State, Medford Whidden Memorial, Everett	
Medfield	Danton Mass. School Hospital				Glover Memorial Needham	Norwood	
Mystic Valley						Symmes, Arlington Choate Memorial, Woburn	
New Bedford					St. Luke's, New Bedford		
Newton					Newton-Wellesley		
Plymouth			Jordan, Plymouth Plymouth				
Quincy					Quincy City Norfolk County		
Reading			New England Memorial, Stoneham		Melrose Wakefield		
Southbridge			Harrington Memorial, Southbridge		Mary Lane, Ware		
Springfield •	Springfield				Mercy, Springfield Wesson Memorial, Springfield Springfield Municipal	Shriner's Hospital for Crippled Children Springfield	
Taunton			Lakeville Morton, Taunton				
Waltham					Waltham Middlesex County Sanatorium, Waltham		
Westborough		Cushing, Framingham				Framingham Union Morse, Natick Marlboro	
Westfield					Western Mass., Westfield	Noble, Westfield	
Worcester	Rehabilitation Center of Worcester		St. Vincent, Worcester Worcester City		Worcester Memorial Worcester County Sanatorium		

[1] Excluded from this survey are the institutions of the Massachusetts Department of Mental Health and Veterans' Administration Hospitals.

[2] Hospitals are rated in seven categories to indicate the maximum services offered at that hospital.

[3] Comprehensive is defined as a coordinated and integrated program with restorative adjustment services within the following three areas: medical, psychological and/or social, and vocational and/or educational. These services must be provided within the facility with a full time professional staff and includes more services than rehabilitation, physical therapy, occupational therapy and social service.

[4] Rehabilitation is defined as adjustment and restorative services in a coordinated and integrated program in two or three of these service areas medical, social or vocational. Also some of their staff is likely to be part time. Services offered include more than physical therapy, occupational therapy and social service

Appendix 6

THE DISTRIBUTION OF NONINSTITUTIONAL WORKSHOP FACILITIES AMONG THE GEOGRAPHIC SERVICE AREAS, BY CLIENT DISABILITY, TYPE OF WORKSHOP, TYPES OF SERVICES PROVIDED[1] AND NUMBER OF CLIENTS SERVICED ANNUALLY

Facilities Within Geographic Service Area	*Client Disability*	*Types of Workshop*	TYPES OF SERVICES									*No. of Clients Served Annually*
			Arts and Crafts	*Vocational Evaluation*	*Personal Adjustment Training*	*Vocational Training*	*Transitional Employment*	*Extended Employment*	*Placement*	*Followup*	*Pre-Vocational Training*	
Barnstable												
Nauset Workshop of Cape Cod Association for the Retarded	Mentally Retarded	T or E/SD									●	8
Berkshire												
Goodwill Industries of Pittsfield Workshop		T or E/M		●		●	●		●			42
Berkshire County Association for Retarded Children, Pittsfield	Mentally Retarded	AC/SD	●									8
Opportunities for the Handicapped, Pittsfield	Mentally Retarded	AC/SD	●									15
Pittsfield Workshop for the Blind	Blindness	T or E/SD						●				6
Boston												
Brookline-Brighton		NONE										
Government Center		NONE										
Roslindale		NONE										
Roxbury-North Dorchester												
Morgan Memorial Goodwill Industries Workshop	Physically Disabled	ET/M		●			●	●	●			1537
South Boston												
Community Workshop	Mentally Retarded	ET/M		●		●	●	●	●	●	●	234
Jewish Vocational Service	Mentally Retarded	ET/M	●	●	●	●	●	●	●	●	●	75
Morgan Memorial New England Rehabilitation for Work Center	Mentally Retarded	T or E/M		●	●	●			●		●	113
Vocational Adjustment Center	Mentally Retarded	ET/SD		●			●	●	●	●	●	75
Brockton		NONE										
Cambridge												
Cambridge Industries for the Blind	Blindness	T or E/SD						●				73
Concord												
Minute Men Association Workshop for the Retarded, Concord	Mentally Retarded	AC/SD							●			16
Danvers												
Heritage Training Center, Salem	Mentally Retarded	T or E/SD					●	●	●	●	●	21
Fall River												
Fall River Workshop for the Blind	Blindness	T or E/SD	●									9
Greater Fall River Association for Retarded Children	Mentally Retarded	T or E/SD	●					●	●			19
United Cerebral Palsy Workshop, Fall River	Cerebral Palsy	AC/SD	●									17

Appendix 6 (Continued)

Facilities Within Geographic Service Area	Client Disability	Types of Workshop	TYPES OF SERVICES									No of Clients Served Annually
			Arts and Crafts	Vocational Evaluation	Personal Adjustment Training	Vocational Training	Transitional Employment	Extended Employment	Placement	Followup	Pre-Vocational Training	
Fitchburg North Worcester County Association for Retarded Children	Mentally Retarded	T or E/SD					●	●	●			23
Foxborough Attleboro Association for Retarded Children	Mentally Retarded	T or E/SD					●	●				8
Franklin-Hampshire Franklin County Association for Retarded Children, Greenfield	Mentally Retarded	AC/SD	●									13
Gardner Gardner Association for Retarded Children	Mentally Retarded	AC/SD	●									8
Grafton		NONE										
Haverhill		NONE										
Holyoke		NONE										
Lawrence Greater Lawrence Association for Retarded Children	Mentally Retarded	AC/SD	●									20
Lowell Merrimack Valley Goodwill Workshop, Lowell	Mentally Retarded	ET/SD		●		●			●	●	●	78
Lowell Workshop for the Blind	Blindness	T or E/SD						●				5
Merrimack Association for Retarded Children	Mentally Retarded	T or E/M				●	●	●	●			5
Lynn Lynn Goodwill Industries Workshops	Multiple Types	ET/M		●	●		●	●	●		●	70
Malden		NONE										
Medfield Charles River Workshop Needham	Mentally Retarded	T or E/SD		●			●	●			●	31
Mystic Valley East Middlesex Association for Retarded Children, Woburn	Mentally Retarded	T or E/M					●	●	●	●	●	21
New Bedford Opportunity Center of Greater New Bedford	Mentally Retarded	ET/SD		●		●	●	●	●			31
Newton		NONE										
Plymouth		NONE										
Quincy Occupational Training Center, Squantum	Mentally Retarded	ET/SD		●		●	●	●	●	●	●	24
Reading		NONE										
Southbridge		NONE										

Appendix 6 (Continued)

Facilities Within Geographic Service Area	*Client Disability*	TYPES OF SERVICES										
		Types of Workshop	*Arts and Crafts*	*Vocational Evaluation*	*Personal Adjustment Training*	*Vocational Training*	*Transitional Employment*	*Extended Employment*	*Placement*	*Followup*	*Pre-Vocational Training*	*No. of Clients Served Annually*
Springfield												
Springfield Goodwill Industries Workshop	Many types	ET/M		●	●	●	●	●	●	●	●	363
Workshop for the Blind, Springfield	Blindness	AC/SD						●				20
Taunton		NONE										
Waltham		NONE										
Westborough		NONE										
Westfield		NONE										
Worcester												
Worcester Occupational Training Center		ET/SD	●	●	●		●	●	●	●	●	100
Worcester Morgan Memorial Goodwill Industries		T or E/M						●				10
Worcester Workshop for the Blind		T or E/SD						●				5

1 Blue dots indicate that specific services are being provided at the particular workshop. Blank spaces indicate a lack of such services.

2 The type of workshops are identified as follows

ET/M Both extended and transitional and multidisciplinary
ET/SD Both extended and transitional but single disability
T or E/M Transitional or extended and multidisciplinary
T or E/SD Transitional or extended and single disability
AC/SD Activity Center, single disability

Appendix 7

VOCATIONALLY ORIENTED SERVICES PROVIDED BY PUBLIC SCHOOL SYSTEMS FOR PHYSICALLY DISABLED, MENTALLY RETARDED, AND EMOTIONALLY DISTURBED CHILDREN, BY TOWNS WITHIN GEOGRAPHIC SERVICE AREAS[1]

		Physically Disabled			*Mentally Retarded*			*Emotionally Disturbed*		
Geographic Service Areas	*Number of Communities in Area*	*Prevocational*	*Vocational*	*Work Experience*	*Prevocational*	*Vocational*	*Work Experience*	*Prevocational*	*Vocational*	*Work Experience*
Barnstable	23	Bourne			Falmouth	Bourne Falmouth Provincetown	Barnstable Bourne Falmouth			
Berkshire	32	Pittsfield	Pittsfield		Dalton Hinsdale Pittsfield	Pittsfield	No. Adams Pittsfield	Pittsfield	Pittsfield	
Boston. Brookline-Brighton Government Center Roslindale Roxbury-N Dorchester South Boston	18	Winthrop	Winthrop	Winthrop	Boston Brookline Chelsea Winthrop	Boston Brookline Chelsea Winthrop	Boston Winthrop	Winthrop	Brookline Winthrop	Winthrop
Brockton	10			Easton	Brockton Easton Rockland	Brockton Easton Holbrook Rockland Stoughton	Brockton Easton Rockland	Easton	Easton	
Cambridge	2				Cambridge Somerville	Cambridge Somerville	Somerville			
Concord	10	Maynard	Maynard	Bedford	Maynard		Bedford			Bedford Maynard
Danvers	14		Beverly	Beverly Ipswich Topsfield (limited)	Marblehead Topsfield	Ipswich Peabody Topsfield	Ipswich Marblehead Topsfield	Topsfield (limited)	Beverly Ipswich Topsfield (limited)	Beverly
Fall River	3				Fall River Freetown	Fall River Freetown Swansea Westport				
Fitchburg	14	Leominster	Leominster		Ayer Leominster Pepperell Townsend	Fitchburg Leominster Pepperell Townsend	Leominster Pepperell			
Foxborough	5				Attleboro No. Attleboro Norton	No. Attleboro Norton	No Attleboro Norton			
Franklin- Hampshire	36				Amherst Buckland Deerfield Northampton	Amherst Deerfield Northampton Shelburne	Amherst Deerfield Northampton Shelburne			
Gardner	19				Athol Royalston Winchendon	Athol Royalston Philipston Templeton Winchendon	Athol Royalston Philipston Templeton Winchendon			
Grafton	15			Milford	Bellingham Blackstone Franklin Grafton Milford	Blackstone Milford	Milford	Milford	Milford	
Haverhill	11				Haverhill	Haverhill	Amesbury			
Holyoke	8	Holyoke	Holyoke		Holyoke Ludlow	Chicopee Holyoke Ludlow				Holyoke

Appendix 7 (Continued)

		Physically Disabled			*Mentally Retarded*			*Emotionally Disturbed*		
Geographic Service Areas	*Number of Communities in Area*	*Prevocational*	*Vocational*	*Work Experience*	*Prevocational*	*Vocational*	*Work Experience*	*Prevocational*	*Vocational*	*Work Experience*
Lawrence	4				Lawrence	Andover	Andover			
Lowell	9					Wilmington	Wilmington			
Lynn	5			Saugus	Saugus	Lynn Saugus	Saugus			
Malden	3				Everett Malden	Everett				
Medfield	11				Dedham	Dedham	Dedham			
Mystic Valley	5				Lexington Woburn	Woburn	Woburn			
New Bedford	8				Dartmouth	Fairhaven	Dartmouth			
Newton	3				Newton	Newton	Newton			
Plymouth	12				Duxbury Hanover Marshfield Plymouth	Hanover Marshfield	Duxbury Hanover Plymouth	Hanover Marshfield Plymouth		Plymouth
Quincy	9	Hull			Braintree Cohasset Hingham Hull Milton Quincy Randolph Scituate	Braintree Cohasset Hingham Hull Milton Randolph Scituate	Braintree Cohasset Hingham Hull Milton Quincy Randolph	Cohasset	Cohasset	Cohasset
Reading	5				Melrose No Reading Reading Stoneham	No. Reading	Melrose No Reading			
Southbridge	18					No. Brookfield	No. Brookfield			
Springfield	5			Wilbraham	E. Longmeadow Longmeadow Springfield Wilbraham	Longmeadow Springfield Wilbraham	Longmeadow Springfield Wilbraham			Wilbraham
Taunton	8				Lakeville Seekonk			Lakeville		
Waltham	3	Waltham	Waltham	Waltham	Belmont Waltham	Belmont Waltham	Waltham			
Westborough	15				Framingham Hudson Natick	Framingham Natick	Ashland Framingham Natick Wayland			
Westfield	11			W Springfield	Huntington Westfield W. Springfield	Westfield W. Springfield	Huntington Westfield W. Springfield			
Worcester	8				Auburn Leicester Worcester Holden Paxton	Auburn Worcester (*Wachu- setts Regional)	Worcester (*Wachusetts Regional)			

[1] This chart indicates which towns provide school programs for each category of disability as communicated by the local school system. Not indicated, however, is the number of children serviced by programs available in each community. The empty spaces denote lack of programs in the area.

Source: Survey of local public schools, rehabilitation programs, by Planning Commission; 1967

VOCATIONAL REHABILITATION PLANNING COMMISSION*

PAUL E. AFFLECK	*Executive Director* Springfield Goodwill Industries, Inc.
†‡W. SCOTT ALLAN	*Assistant Vice President* Liberty Mutual Insurance Companies
OTTILIE M. BANKS	*Supervisor* *Rehabilitation Services, Medical Assistance Division* Massachusetts Department of Public Welfare
VINCENT BARNABA, M.D.	*Director* Berkshire Rehabilitation Center, Inc., Pittsfield
KARL T. BENEDICT, M.D.	*Medical Director* Norton Company, Worcester
ROSALIND POLL BROOKER	*Legal Advisor, Board of Directors* Opportunity Center of Greater New Bedford, Inc.
EDWIN D. CAMPBELL	*Executive Vice President* Itek Corporation, Lexington
SISTER MARY CARL	*Supervisor, Teacher Training Program* Boston School for the Deaf, Randolph
†REV. THOMAS J. CARROLL	*Executive Director* The Catholic Guild for All the Blind, Newton
PHILLIP CASHMAN, ED.D.	*Assistant Commissioner of Education* Massachusetts Department of Education
ARTHUR CIAMPA	*Executive Director* Cerebral Palsy of the South Shore Area, Inc.
HELEN P. CLEARY	*Doctoral Student* Harvard School of Public Health
†GERALD E. CUBELLI	*Program Director* Psychiatric Rehabilitation Internship Program Massachusetts Mental Health Center
DAVID CUTLER	*Administrator, Information Processing Systems* Raytheon Company
LESLIE B. CUTLER	*State Senator*, Needham
VERNON R. FARNSWORTH	*State Representative*, Wilbraham
VIRGINIA GODEK	*Member, Mayor's Committee on Mental Health* City of Chicopee
R. GORDON GRANGER	*Treasurer* Greater Barrington Savings Bank
HARRIET GRISWOLD	Belmont, Massachusetts
†FRANCIS A. HARDING	*Former Commissioner,* Massachusetts Rehabilitation Commission
DAVID E. HARRISON	*State Representative*, Gloucester
LUKE S. HAYDEN	*President* City Savings Bank of Pittsfield
HENRY E. HELMS	*Executive Director* Morgan Memorial, Inc.
MYER HERMAN, M.I	*Director, Division of Adult Health* Massachusetts Department of Public Health
WESTON HOWLAND	*Past Member* Advisory Council to Vocational Rehabilitation Administration
†KATHARINE D. KANE	*State Representative*, Boston
GREGORY B. KHACHADOORIAN	*State Representative*, Arlington

PLANNING COMMISSION (Continued)

LEWIS B. KLEBANOFF, PH.D.	*Deputy Assistant Commissioner for Mental Retardation* Massachusetts Department of Mental Health
MATTHEW O. KULUNGIAN, JR.	*Director, Veterans Services* Springfield
RICHARD A. LAPIERRE	*Executive Director* Easter Seal Society for Crippled Children and Adults of Massachusetts, Inc.
†JOHN S. LEVIS	*Commissioner* Massachusetts Rehabilitation Commission
JOHN W. LUND	*President* New England Envelope Company
STEPHEN D. MERRICK	*Chairman* Industrial Accident Rehabilitation Board
JOHN F. MUNGOVAN	*Commissioner* Massachusetts Commission for the Blind
VALENTINE P. MURPHY	*President* Greater Boston Labor Council, AFL-CIO
WILLIAM A. PHILBRICK, JR.	*Director, Bureau of Special Education* Massachusetts Department of Education
†DONALD S. PIERCE, M.D.	*Chief, Department of Rehabilitation Medicine* Massachusetts General Hospital
†§IRVING RABB	*Vice Chairman of the Board* Stop & Shop, Inc.
LOUIS ROBERTS	*Chief, Microwave Laboratory* National Aeronautics and Space Administration Cambridge
REV. EMERSON WESLEY SMITH	*Executive Director* Council of Churches of Greater Springfield, Inc.
PAUL SONNABEND	*Executive Vice President* Hotel Corporation of America
GWENDOLEN C. SMITH	*Reference Librarian* Andover Public Library
†WILLIAM F. STEARNS	*President* Human Relations Service of Wellesley, Inc.
HAROLD M. STERLING, M.D.	*Past Director* Rehabilitation Institute New England Medical Center Hospital
THOMAS N. WARD	*Past President, Board of Directors* Greater Lawrence Association for Retarded Children
ARTHUR G. WEAVER	*Vice President* John Hancock Mutual Life Insurance Company
HENRY W. WEBSTER	*Past President* Morgan Memorial, Inc.
M. JANE WELSH	*Rehabilitation Associate* United Community Services of Metropolitan Boston

*Positions and affiliations held at time of appointment to Planning Commission.

‡Chairman

§Treasurer

†Member, Executive Committee

TASK FORCE MEMBERS[1]

ADMINISTRATION

IRVING RABB
Vice Chairman of the Board
Stop and Shop, Inc.

W. SCOTT ALLAN
Assistant Vice President
Liberty Mutual Insurance Companies

EDWIN D. CAMPBELL
Executive Vice President
Itek Corporation

REVEREND THOMAS J. CARROLL
Executive Director
The Catholic Guild for All the Blind
Newton

GORDON B. CONNOR, ED.D.
Director of Rehabilitation Services
Morgan Memorial, Inc.

DONALD H. GUILD
Mechanical Engineer
Stone & Webster Engineering Corporation

JOHN S. LEVIS
Commissioner
Massachusetts Rehabilitation Commission

MARTIN A. LINSKY
State Representative, Brookline

ELWYN E. MARINER
Research Director
Massachusetts Taxpayers Foundation, Inc.

ARTHUR G. WEAVER
Vice President
John Hancock Mutual Life Insurance Company

Project Staff.

FRANKLIN B. FOGELSON, PH.D.
Planning Associate

C. DAVID HILBURN, LL.B.
Legal Counsel

EDWARD NEWMAN, PH.D.
Executive Director

COMMUNITY SERVICES

*HAROLD W. DEMONE, JR., PH.D.
Executive Director
United Community Services of Metropolitan Boston

ARNOLD ABRAMS, M.D.
Regional Administrator for Mental Health, Region III
Massachusetts Department of Mental Health

OTTILIE M. BANKS
Supervisor of Rehabilitation Services
Massachusetts Department of Public Welfare

VINCENT BARNABA, M.D.
Director
Berkshire Rehabilitation Center, Inc

ELMER C. BARTELS
Vice President
Massachusetts Association of Paraplegics, Inc.

MARY T. BARTELS
Secretary
Massachusetts Association of Paraplegics, Inc.

EDMUND BURKE, PH.D.
Chairman, Community Organization and Social Planning
Boston College Graduate School of Social Work

ROBERT F. CAHILL
Executive Director
Community Services of Greater Worcester, Inc.

ARTHUR CIAMPA
Executive Director
Cerebral Palsy of the South Shore Area, Inc.

KAREL J. DEHAAS, M.D.
Superintendent
Hathorne State School

HARVEY EVANS
Senior Supervisor, Physical Restoration
Massachusetts Rehabilitation Commission

SIDNEY HARMON, M.D.
Chief, Department of Physical Medicine and Rehabilitation
New England Hospital

KATHARINE D. KANE
State Representative, Boston

MELVIN KING
Executive Director
Urban League of Greater Boston

MANUEL J. MELLO
Executive Director
Massachusetts Association for Retarded Children, Inc.

EDWARD NEWMAN, PH.D.
Executive Director
Vocational Rehabilitation Planning Commission

HUNTLEY NICHOLAS
District Supervisor, Roxbury
Massachusetts Rehabilitation Commission

GEORGE O'SHEA
Welfare Consultant
Executive Office of Administration and Finance

S. STEVEN ROSNER
Executive Director
Massachusetts Association for Mental Health, Inc.

LEON STERNFELD, M.D.
Deputy Commissioner
Massachusetts Department of Public Health

JOAN TURNER
Associate Director
Easter Seal Society

Project Staff:

WALTER F. STERN, PH.D.
Associate Director

MRS. ROSEMARY WHITING
Planning Assistant

[1]Positions and affiliations at time of appointment to Task Forces
*Chairman

EARLY CASEFINDING AND PREVENTION

HAROLD T. PHILLIPS, M.D.
Chief, Bureau of Chronic Disease Control
Massachusetts Department of Public Health

LENIN A. BALER, PH.D.
Associate Professor, Community Mental Health
University of Michigan School of Public Health

MARY BLACKBURN
Massachusetts Chapter,
National Rehabilitation Association

LAURENCE B. ELLIS, M.D.
Chief, Cardiac Clinic
Boston City Hospital

FRED H. FRANKEL, M.D.
Assistant Professor
Harvard Medical School

MYER HERMAN, M.D.
Director, Division of Adult Health
Massachusetts Department of Public Health

HAZEL KEITH
Executive Director, District V
Massachusetts Nurses Association

JOSEPH MAYER, PH.D.
Executive Director
Washingtonian Hospital

LEONA G. NEWMAN
Information, Counseling and Referral Services
Easter Seal Society, Springfield

HAROLD STERLING, M.D.
Physiatrist in Chief
Department of Physical Medicine and Rehabilitation
Tufts Medical School

Project Staff:

BERNARD GRAY, PH.D
Research Director

VOCATIONAL EVALUATION, TRAINING AND EDUCATION

‡SIMON OLSHANSKY
Executive Director
Community Workshops, Inc.

‡DONALD S. PIERCE, M.D.
Director, Rehabilitation Unit
Massachusetts General Hospital

VINCENT BARNABA, M.D.
Director
Berkshire Rehabilitation Center, Inc.

KARL T. BENEDICT, M.D.
Medical Director
Norton Company, Worcester

JOHN BRENNAN, PH.D.
Counseling Psychologist
Bedford V.A. Hospital

CELIA COOPER, PH.D.
Coordinator
Rehabilitation Counselor Training Program
Springfield College

MARION CRAMPTON
Supervisor of Occupational Therapy
Massachusetts Department of Mental Health

FRANCIS E. N. DECAPOT
Workshop and Rehabilitation Facilities Specialist
Massachusetts Rehabilitation Commission

TAMARA DEMBO, PH.D.
Professor of Psychology
Clark University, Worcester

JOHN EICHORN, PH.D.
Director, Special Education and Rehabilitation
Boston College

JOEL FRIEDMAN, PH.D.
Director of Psychological Research
North Suffolk Mental Health Center

RICHARD T. GOLDBERG, ED.D.
Director of Research
Massachusetts Rehabilitation Commission

FRANK S. GREENBERG
Chief of Client Services
Morgan Memorial, Inc.

DONALD GREENE, M.D.
Chief, Department of Neurology
New England Hospital

INEZ E. HEGARTY, PH.D.
Associate Professor of Speech
University of Massachusetts, Amherst

NORMAN A. KIRK
Founder and Past President
Massachusetts Association of Paraplegics

ROBERT P. LANGFORD, PH.D.
Executive Director
Rehabilitation Center of Worcester, Inc.

†HAROLD LEE, M.D.
Assistant Superintendent
Medfield State Hospital

PAUL PRIMAVERA
Mental Health Supervisor, Quincy
Massachusetts Rehabilitation Commission

HILMA UNTERBERGER
Alcoholism Coordinator
Massachusetts Department of Public Health

WESLEY G. WOOD, JR., M.D.
Chief of Physical Medicine and Rehabilitation
Lemuel Shattuck Hospital

Project Staff:

WALTER F. STERN, PH.D.
Associate Director

MELVIN E. COHEN, ED.D.
Program Development Director

Chairman

Vice-Chairman

†Deceased

GERALD E. CUBELLI
Program Director
Psychiatric Rehabilitation Internship Program
Massachusetts Mental Health Center

GEORGE F. ARSNOW
Supervisor in Education
Massachusetts Commission for the Blind

JOHN S. BURNS
Director of Case Services
Massachusetts Rehabilitation Commission

RONALD CONANT
Administrative Assistant
Community Workshops, Inc.

FRANCIS X. FITZGERALD
Director
Vocational Adjustment Center
Greater Boston Association for Retarded Children

WILLIAM F. FRARY
Supervisor of Guidance, Placement and Followup of Retarded Children
Massachusetts Department of Education

EARL FROST
Coordinator, Physical Medicine and Rehabilitation Services
Brockton V.A. Hospital

SAMUEL GROB, PH.D.
Executive Director
Center House Foundation

HARRY HALLIDAY
Program Coordinator
Rutland Heights Mental Health-Rehabilitation Center

EMIL M. HARTL, PH.D.
Rehabilitation Coordinator
Morgan Memorial, Inc.

JEAN C. HILLSEN
Senior Field Representative
Easter Seal Society

SIMON HOFFMAN, ED.D.
Executive Director
Jewish Vocational Services

ERNEST JACOBY
Director
North Bennet Street Industrial School

*Chairman

HAROLD D. KASTLE
Manager, Employee Benefits
Raytheon Company

MATTHEW LUZZI
Assistant Coordinator
Rehabilitation Counselor Training Program
Boston University

ROBERT L. MATTHEWS
Vocational Counselor
Rehabilitation Institute
Liberty Mutual Insurance Company

EDWARD MCHUGH
Senior Supervisor, Placement
Massachusetts Rehabilitation Commission

GERARD MOLONEY
Program Planner
Massachusetts Rehabilitation Commission

ISADOR MORANTZ
Supervisor of Services to Selected Applicant Groups
Massachusetts Division of Employment Security

DELILAH REIMER, M.D.
Director
North Reading Rehabilitation Center

ROY M. SHULMAN, M.D.
Instructor in Psychiatry
Boston University Medical School

JOSEF E. TEPLOW
Vice President
Ward Machine Company, Inc., Brockton

NICHOLAS H. THISSE
Workshop Director
PROP, Inc.
Boston State Hospital

EUNICE TURGEON
Chief Supervisor
Massachusetts Division of Employment Security

Project Staff:

MELVIN E. COHEN, ED.D.
Program Development Director

PROFESSIONAL TRAINING AND MANPOWER

ARTHUR J. BINDMAN, PH.D.
Regional Administrator for Mental Retardation, Region VI
Massachusetts Department of Mental Health

GEORGE W. CRANTON
Senior Community Action Technician
Commonwealth Service Corps

VERONICA C. DOBRANSKE
Chairman, Boston School of Occupational Therapy
Tufts University

WALTER E. DUGGAN
Supervisor of Guidance, Placement and Followup
Massachusetts Department of Education

MILDRED FLASHMAN
Adjunct Associate Professor
Boston University School of Social Work

ROBERT E. FLYNN, M.D.
Director
Community Evaluation and Rehabilitation Center
Walter E. Fernald State School, Waltham

EMMANUEL B. GREEN, PH.D.
Coordinator, Rehabilitation Counselor Training Program
Boston University School of Education

SUZANNE B. GREENBERG
Director, Training Center for Comprehensive Care
Lemuel Shattack Hospital

RICHARD HULL
Supervisor in Mental Health, Somerville
Massachusetts Rehabilitation Commission

HUBERT E. JONES
Executive Director
Roxbury Multiservice Center

JAMES MCCOURT, ED.D.
Coordinator, Counseling Psychology Service
Brockton V.A. Hospital

JOHN F. MUNGOVAN
Commissioner
Massachusetts Commission for the Blind

LENA PLAISTED
Chairman, Rehabilitation Nursing Program
Boston University School of Nursing

DEREK ROBINSON, M.D.
Assistant Director
Bureau of Chronic Disease Control
Massachusetts Department of Public Health

JOEL SAMUELS
Supervisor in Physical Restoration, Quincy
Massachusetts Rehabilitation Commission

VIRGINIA SNIVELY
Public Health Advisor
Massachusetts Department of Public Health

ALAN B. SOSTEK, PH.D.
Director, Rehabilitation Administration Division
Department of Special Education and Rehabilitation
Northeastern University

Project Staff:

WALTER F. STERN, PH.D.
Associate Director

MELVIN E. COHEN, ED.D.
Program Development Director

RESEARCH

*ANDREW S. DIBNER, PH.D.
Associate Professor, Department of Psychology
Boston University

MORRIS AXELROD, PH.D.
Director, Community Research Project
Combined Jewish Philanthropies

BURTON BLATT, ED.D.
Assistant Commissioner for Mental Retardation
Massachusetts Department of Mental Health

ELIZABETH K. CASO
Director of Community Services
Division of Adult Health
Massachusetts Department of Public Health

RICHARD T. GOLDBERG, ED.D.
Director of Research
Massachusetts Rehabilitation Commission

*Chairman

LESTON HAVENS, M.D.
Regional Administrator for Mental Health, Region VI
Massachusetts Department of Mental Health

PETER NEW, PH.D.
Associate Professor
Department of Preventive Medicine
Tufts University

AGNES B. SULLIVAN
Supervisor of Welfare Statistics
Massachusetts Department of Public Welfare

JOAN TURNER
Associate Director
Easter Seal Society

JOHN M. TYLER, M.D.
Chief of Professional Services
Lemuel Shattuck Hospital

Project Staff:

BERNARD GRAY, PH.D.
Research Director

ARCHITECTURAL BARRIERS

‡CHARLES F. QUIGLEY
Prisident
Robert Charles Associates, Inc.

‡RICHARD A. LAPIERRE
Executive Director
Easter Seal Society

ELLIS ASH
Administrator
Boston Housing Authority

PHILIP G. BRONSTEIN
Real Estate Trustee, Boston

L. ROBERT CAMPBELL
President
Ware Savings Bank

GEORGE J. COLLINS, ED.D.
Assistant Commissioner of School Facilities and
Related Services
Massachusetts Department of Education

FRANK W. CRIMP
Crimp, Brown, & Fisher, Inc.

HAROLD E. FINE
Vice President, Construction and Engineering Department
Stop and Shop, Inc.

BENJAMIN FINK
Director, Park Engineering Division
Metropolitan District Commission

JOSEPH GLYNN
Principal Civil Engineer, Bureau of Building Construction
Executive Office of Administration and Finance

HARRIET GRISWOLD
Belmont

RT. REV. EDMUND G. HADDAD
Chancellor
Our Lady of Fatima Rectory

DAVID P. HAYES
President
Massachusetts Association of Paraplegics

CHARLES HILGENHURST
Director of Urban Design
Boston Redevelopment Authority

GREGORY B. KHACHADOORIAN
State Representative, Arlington

REV. ROLAND S. LARSON
Director of Planning
Interfaith Housing Corporation

JOHN MAKINEN
Chief Architect
Federal Housing Administration

DOAK MARTIN
Martin and Williams

FRANK W. MORRIS
Acting Counsel, Division of Housing
Massachusetts Department of Commerce and Development

ROBERT H. ROWE
Senior Planner, Research and Development Department
Massachusetts Bay Transit Authority

JULIUS J. SOFINOWSKI
Deputy Commissioner, Division of Housing
Massachusetts Department of Commerce and Development

PAUL SONNABEND
Executive Vice President
Hotel Corporation of America

EDGAR H. WOOD
President, Massachusetts Council
Society of American Registered Architects

JOSEPH YANTOSCA
Supervisor of Plans, Building Inspection Division
Massachusetts Department of Public Safety

Project Staff:

M. JANE WELSH
Rehabilitation Associate
United Community Services of Metropolitan Boston

PUBLIC OFFENDER

*MARTIN A. LINSKY
State Representative, Brookline

JOHN BORYS
Research Analyst
Governor's Committee on Law Enforcement and
Administration of Justice

JOSEPH [illegible]RACK
Chief Supervisor of Psychiatric Social Work
Massachusetts Department of Correction

JOSEPH I. CULLEN
Director of Psychological Research
Division of Youth Services

CHARLES V. FALLS
Chief Parole Supervisor
Parole Board

JOSEPH P. FOLEY
Deputy Commissioner of Probation

GEORGE L. KEEFE
Supervisor of Special Services
Parole Board

RICHARD KINSELLA
Director, Aftercare Clinic
Division of Legal Medicine
Massachusetts Department of Mental Health

WILLIAM KIRSCHNER
Hyde Park

EDWIN LAPEDIS
Consultant
National Council on Crime and Delinquency
Massachusetts Chapter

LEO LONG
Senior Supervisor, Public Offender Program
Massachusetts Rehabilitation Commission

HENRY J. MASCARELLO
Executive Director
Massachusetts Correctional Association

ARTHUR M. MASON
Special Justice
First District Court of Southern Middlesex

ANGELO MUSTO
Deputy Commissioner of Probation

Project Staff:

MELVIN E. COHEN, ED.D.
Program Development Director

FRANK J. LASKI, L.L.B.
Legal Counsel

‡Co-Chairman *Chairman

TECHNOLOGICAL CHANGE AND OCCUPATIONAL PATTERNS

‡EMMANUEL G. MESTHENE, PH.D.
Director, Harvard Program on Technology and Society

‡VALENTINE P. MURPHY
President
Greater Boston Labor Council, AFL-CIO

J. WILLIAM BELANGER
Director
Massachusetts Division of Employment Security

GORDON BRUMM, PH.D.
Lecturer, Department of Philosophy
Northeastern University

DANIEL CANTOR
Vice President, Employee Relations
Itek Corp.

ALEXANDER CELLA
Legislative Assistant to the Speaker of the
House of Representatives

BERYL COHEN
State Senator, Brookline

JOHN DUNLOP, PH.D.
Professor of Political Economics
Harvard University

ARNOLD GURIN, PH.D.
Professor of Social Administration
Brandeis University

ALBERT F. KAHN, PH.D.
Associate Professor of Education
Boston University

JOHN KNOWLES, M.D.
Director
Massachusetts General Hospital

PHILIP KRAMER
Vice President
International Ladies' Garment Workers Union

PAUL MCGERIGLE
Research Specialist
Executive Office of Administration and Finance

JOHN P. MURRAY
Personnel Manager
American Sugar Company

HELEN TAFE O'DONNELL
Vice President
Massachusetts State Labor Council, AFL-CIO

FR. THEODORE PURCELL
Director
Cambridge Center for Social Studies

IRVING RABB
Vice Chairman
Board of Directors
Stop and Shop, Inc.

HARVEY I. REMMER, M.D.
Assistant Director
Division of Adult Health
Massachusetts Department of Public Health

ELINOR ROWE
Chief of Research
Massachusetts Division of Employment Security

BEN B. SELIGMAN
Professor of Economics
University of Massachusetts

ROY STEVENS
Director, District I
United Steelworkers of America

MARX W. WARTOFSKY, PH.D.
Chairman, Department of Philosophy
Boston University

DONALD J. WHITE, PH.D.
Professor of Economics
Boston College

IRVING K. ZOLA, PH.D.
Associate Professor, Department of Sociology
Brandeis University

Project Staff:

LEONARD BLOKSBERG, PH.D.
Planning Associate

‡Co-Chairman