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ABSTRACT

This study asked a group of 70 rehabilitation leaders to: (1) project the major tasks of the rehabilitation counselor in the future; (2) to comment upon the goals which would guide him; and (3) to speculate on the new settings in which the counselor would work, the kinds of clients he would serve and the types of services he would provide. Rehabilitation leaders were unanimous in anticipating that the 1980 counselor would work with a broader range of clients, particularly the disadvantaged, that there would be less restriction upon client selection, and that the counselor would work not only with clients who are physically handicapped but also with those who have all kinds of adjustment problems. In the future, rehabilitation counselors will need to cope with these developments: (1) the reordering of national priorities; (2) the impact of the current manpower shortage on rehabilitation services; and (3) the calls for greater accountability on the part of counselors and agencies. (Author/LAA)

The Future Roles of the Rehabilitation Counselor

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I. Projections of Rehabilitation Leaders

Today we call those with the temerity to speculate on the future futurists. Paul and I do not aspire to such status. What we want to do is briefly report on the speculations and predictions about the work of the rehabilitation counselor in 1980. In the main, our discussion will summarize the expectations rehabilitation leaders noted during the course of the roles and functions study which Paul and I undertook for ARCA. In addition, we want to offer some of our own speculations.

As part of the roles and functions study we asked a group of 70 individuals, who because of their positions and roles were rehabilitation leaders in 1966, to systematically describe the major tasks of the rehabilitation counselor in the future and to comment upon the goals which would guide him in 1980. For this study, leaders in rehabilitation (RL) included persons in the following positions or settings:

1) Directors or program administrators of rehabilitation centers and facilities (N-12),
2) Rehabilitation counselor educators (N-13), and
3) State DVR directors and directors of Commissions for the Blind, and Vocational Rehabilitation Administration personnel at the national and regional levels (N-25).

They were also asked to speculate on the new settings in which the counselor would work, the kinds of clients he would serve and the types of services he would provide. As you will see, the rehabilitation leaders include occasional high-flying futurists, but for the most part step into the future with one foot still in touch with the past.

Let's first look at the rehabilitation leaders' responses to the Abbreviated Rehabilitation Counselor Task Inventory (TI) which consists

of 40 statements of counselor activities in counseling, vocational and social diagnosis, psychological testing, arrangement and coordination of rehabilitation services, placement and follow-up, and collaboration with other rehabilitation workers. The TI data showed that rehabilitation facility administrators, counselor educators and state and federal administrators do not differ in their projections of the extent to which future counselors will perform various job activities. The results also indicated that the rehabilitation leaders did not think the level of involvement in specific job tasks for rehabilitation counselors will change to any great extent. RL expected counselors to become more active in building client work motivation, group counseling, placement and follow-up, and collaboration with other rehabilitation workers, and less engaged in psychological test administration and medical information decision making.

The responses of the RLs to four open-ended questions were more provocative although more difficult to summarize. From reactions to the question, "How will his goals be different than for present day counselors?", we noted several themes. One was the anticipated broadening of the counselor's responsibilities to include concern for the total development of the client and his family and extensive follow-up services. However, several thought the counselor would relinquish responsibility for placing the client in a job and expect that task to be taken over by the specialists. Such views are exemplified by statements like:

> "He will deal more with social, cultural and environmental handicapping factors", and
>
> "Not only to work with the client but also with the family constellation. Those goals will involve total adjustment of the client to more than they do currently."

A second theme with respect to goals was that of broadening services so that individuals who because of age, disability or circumstances were not employable but needed help to adapt to their circumstances. For example:

> "His rehabilitation objectives will not be confined to vocational reinstatement but will be whatever is needed by the client for effective functioning. Among his important goals will be prevention."

Leaders in this group differed in the degree to which they saw vocational adjustment for clients as the future counselor's primary goal. Some expected this goal to be emphasized even more and another small minority expected the counselor to turn away from the vocational emphasis. However, most thought there would be a broadening of the goals counselors would set with their clients rather than a strong de-emphasis on vocational goals.

Rehabilitation leaders working within the state/federal program in nearly all instances saw a continuation of the concern for helping the client become employable. About half of the group saw little change in goals but expected some change in emphasis. For example:

> "Although the major emphasis will continue to be on vocational goals, we will recognize and give increasing concern to the fact that many of our clients will not be full-time workers."
>
> "The goals should be the same, the difference will be the methods of achieving them."
>
> "Goals will be concerned with assisting client to develop and maintain highest potential of self-sufficiency and social contribution with or without remunerate work as we now conceive of it."

For the rehabilitation leaders outside the state/federal program, many predicted the rehabilitation counselor would enter correctional settings, community hospitals and other community based programs to a much larger extent than in the past. A few saw the counselor more frequently based in school settings.

Few of this group mentioned the extent to which the worker in the new settings would be an integral part of the state VR system. However, this pattern of extending VR services seems to have held for many programs which have been set up in prisons, correctional centers, and mental health community centers and mental hospitals. In a similar vein, the state/federal leaders thought the rehabilitation counselor would be found more often in community settings such as schools, prisons, rehabilitation facilities, and the like. For the leaders in public programs there was also a fairly frequent mention of the counselor working in the community with public welfare clientele. Two responses which reflect this expectation are: the counselor will work in comprehensive service centers "where all the needs of all the indigent, disadvantaged and disabled are met" and "possibly to a much greater degree in institutions dealing with people in trouble--prisons, half-way houses, mental hospitals, correctional schools, and the like."

Rehabilitation leaders were unanimous in anticipating that the 1980 counselor would work with a broader range of clients, particularly the disadvantaged. Along with it was an expectation that there would be less restriction for client selection and that the counselor would work with clients who are not only physically handicapped but also have all kinds of adjustment problems. Typical of such responses is one state director's forecast that counselors would work with "all persons needing specialized help in securing and retaining suitable positions in the community" and

another state director's expectations that the clientele will ultimately serve the "educationally, socially, economically disadvantaged (disabled) as well as the traditionally handicapped group." A substantial minority expected "that the client would be the person who is not productive but who has a potential for productivity after training."

In predicting possible changes in the range of services the counselor will provide, most state/federal professionals mentioned a broad range of services or more complex services. More emphasis was expected upon conventional activities such as job placement, follow-up services and supportive counseling after placement as well as the novel (for VR in 1967) provision for family services. As one regional office representative put it, "More services will be provided in the context of family needs rather than individual needs." Another major theme with several state directors in the group was the expectation that there would be less concern with physical restoration and a greater variety of educational, social and vocational services. A few state directors anticipated that technological developments in orthotics and prosthetics would lead to dramatic changes in physical restorations.

Rehabilitation leaders in the private and university sector often mentioned the probability of greater specialization by the counselor along with increased emphasis upon the counseling or vocational adjustment role. They also thought there would be more emphasis on psychological adjustments. "Thus more counseling, comprehensive evaluations, training, placement and especially more effective follow-up services."

Although many members in both leader groups expected that 1980 would see a notable change in the range and breadth of services, it is noteworthy that about half of the group anticipated relatively little change in the pattern of counseling services. The same leaders tended to see services being

improved through specialization or refocusing the counselor's efforts upon critical aspects of the rehabilitation process, rather than through major changes in counseling procedures or the delivery of case services.

In reacting to an open-ended question asking for supplemental comments, one of the more provocative was provided by a specialist in rehabilitation and occupational medicine who thought, "our current and pending legislation demands strong, aggressive counselors to get programs going. We need a greater public image of the counselor. He must be a person, who, all of his life, planned to be a counselor and must not be a medical school drop-out or a lower IQ health activities aspirant. We need sharp, bright non-passive leaders who can hold their heads up with the rest of the team." To the same question a prominent rehabilitation educator urged, "the professional organizations of rehabilitation counselors to exercise leadership in establishing his identity and strengthening his confidence. Interorganizational rivalries (especially ARCA vs NRCA) must be brought to an end soon." To some degree that particular plea has proven prophetic since the two rehabilitation counselor associations have undertaken a series of joint professional activities.

More dramatically, one facility administrator expected that VRA would be no more, "all services, except medical, would be provided by the Labor Department in Manpower Centers. They will use multidisciplinary staff--the rehabilitation counselor as he now exists will be no more since specialized staff can do a much better job--the days of the generalists are numbered." Although the Department of Labor manpower programs and Community Service Administration case service programs have assumed an increasing rehabilitation aura and orientation, the likelihood that there will be no place for the competent rehabilitation counselor still appears rather remote. It seems

that the rehabilitation counselor, especially those with an M.A. level education, have proven capable of adapting to new programs and undertaking more complex and responsible jobs than their counterparts in public welfare and employment service offices. One sign of this phenomenon is the extent to which rehabilitation counselors, especially well-qualified counselors, attain administrative positions in new programs while interviewers and caseworkers may be found migrating to the rehabilitation agency fold. To some extent, these comments may be chauvinistic or defensive but on the other hand they point to the viability of the individualized rehabilitation approach and the lasting value of basic rehabilitation counselor education programs.

II. The Future of Rehabilitation Counselors

In the immediate future, rehabilitation counselors, educators and administrators will need to cope with three major developments. They are: 1) the re-ordering of national priorities and goals, 2) the impact of the current manpower shortage on rehabilitation services and present steps being taken to alleviate this insufficiency and 3) the trend toward gre accountability of counselors and agencies. Although the extrapolation from past trends to future trends in social service programs and our ideas about changing social philosophy may be hazardous, the first development is already upon us. The current emphasis upon reducing dependency through service to individuals who are receiving public assistance will be a major determinant of the type of clients and also the type of services which counselors will provide. The increasing concern among legislators and the executive branch for the plight of the aged may also have long run implications for counselors.

When these current priorities are linked with the present national concern for delivering health services to all people who need it and the

debates about welfare reform and income maintenance, it seems clear that the future is likely to have the rehabilitation counselor, or someone with talents like his, working with an even broader and more numerous clientele than he currently serves.

As a consequence of the increased demand for services to facilitate the work and life adjustment of the economic and otherwise disabled disadvantaged, I anticipate that there will be a continuing strong demand for individuals capable of providing work and life adjustment services.

It is not only the current legislative discussions which suggest the need for an expansion of rehabilitation services, but also the rising expectations for viable programs in the health and income maintenance areas and the changing social philosophy which they seem to reflect. The changing social climate has had a strong impact on the present national administration. Responding to a public mandate, a conservative administration has reacted by proposing a welfare reform bill which lays the groundwork, however inadequate, for income maintenance. The fact that the present administration has proposed programs in many social service areas reflects a belief that the American people think these services are desirable and are willing to pay for them. There is, of course, the possibility that with a second term President Nixon might revert to a more conservative stance in his social service planning. However, it appears unlikely that the Congress will agree to a dismantling of various service programs.

As we see it, the consequences of this increased concern for ameliorating the plight of our disadvantaged citizens will be a marked increase in the demand for rehabilitation-type services, as well as some changes in the administrative arrangements for delivering such services. It seems likely

that by 1980 many of the independent and dispersed agencies which provide fragmented services to the disadvantaged will be functioning within a state/federal system which unifies the services in a more efficient manner. Within this framework, program coordination and integration will be established at a level beyond what is now possible because of interfering regulations, petty rivalries, and the cost in time and energy imposed by physical distance between agencies. Within such multi-service centers the professionals and other workers involved will collaborate in small teams to meet the needs of particular clients. They will request the services of specialists who may be a part of the organization, or if that is not economical, be available on a consultation basis.

Such programs will likely require professional individuals of different types and varying levels of competence. Their widespread introduction will result in a move away from the rehabilitation or social work generalists so that individuals with competencies in vocational and psychological counseling will spend more time with clients who need such services and spend relatively little time providing the coordinating and expediting services. In the multi-service center the main needs of clients will determine which team member would have primary responsibility for assisting the specific client. Such an arrangement will probably increase the need for individuals prepared at the baccalaureate level to function effectively as social service and rehabilitation specialists. These specialists will not need to have extensive preparation in conducting intensive counseling interviews but will instead be expected to have a broad knowledge of the individual, community services and the basic skills involved in providing a helping relationship.

Similarly, the work of the integrated program will provide an opportunity for individuals who have high school or junior college level preparation to

function as placement specialists and expediters of rehabilitation and social services. At the bottom of the career ladder we envision will be the academically unqualified person who will work with special client groups as an outreach person. He might serve as a bridge between the minority group client and the social service team. In addition, if a minority group member he will be a consultant to his colleagues on the special problems and needs of the group of his origin.

Thus, one consequence of the anticipated development and change of national priorities is the likely increase in educational programs at the bachelor's degree level designed to meet the manpower needs of the rehabilitation and social services. Although this may be distressing to some rehabilitation counselor educators, it is my personal view that such a development might serve to strengthen and clarify the roles and functions of the professionally qualified rehabilitation counselor. I believe it could also lead to better counseling for clients and greater work satisfaction for counselors. Such a change may require some M.A. programs to change to a bachelor's program or to add a bachelor's curriculum to the programs' responsibilities. It may also strengthen the graduate programs by providing a relevant undergraduate background for individuals having an interest in and commitment to rehabilitation or social services.

Furthermore, with an undergraduate program as a base for graduate study, educators will be better able to prepare counselors to perform the psychological counselor role. With such an undergraduate background the vocational components of counselors' preparation can be strengthened. Counselors can develop an increased capability to assist clients with occupational exploration, vocational decision-making and vocational adjustment. With junior college-type programs preparing individuals to be human relation aides, a reality

which exists in many communities now, it would be essential to establish a workable job ladder which will enable supportive personnel with the interest, commitment and talent to progress in the rehabilitation field.

As we look to the future work of rehabilitation counselors it seems likely that our group, as even the medical profession, must move eventually to assessing the extent to which those who profess rehabilitation counseling as a profession are abreast of the best present procedures. It seems likely that we will not be satisfied with life-time qualification for counselors, but may, within the decade, elect to require our peers to show through examination or proficiency examinations a knowledge of and competence in applying the best current practices.

Clearly, the next decade will be a time of change and challenge. From their long history of useful service and continued growth, it seems reasonable to expect that rehabilitation counselors will cope with the new realities and accept the challenges to grow and improve their capabilities. Leadership to promote positive community change and a strong advocacy for client rights will be the rehabilitation counselor's privilege and responsibility. I look for a hopeful and exciting future in rehabilitation for the rehabilitation counselor.