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AUTHOR Goldston, M. H., Jr.; Hefley, Robert J.
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ABSTRACT

The project was designed to demonstrate the feasibility and effectiveness of providing faster, more relevant, and more comprehensive diagnostic services to vocational rehabilitation clients with a wide range of disabilities. The improved services were provided by an Experimental Unit (E) and compared with those of a Control Unit (C). The random assignment of physically disabled, alcoholic, mentally ill, and mentally retarded clients to E and C groups and procedures used for each group are presented. The following components used with E referrals are described: audiovisual orientation, vocational rehabilitation-oriented social evaluation interview, psychological testing, short-term work evaluation, faster general medical examination, medical transcription, and transportation. Thirteen variables on which it was hypothesized that the E Group would be found superior to the C Group are listed. Results, based on 749 E and 722 C cases, are reported in 20 tables (Appendix A) and analyzed in narrative form. Findings revealed successes in some areas but indicate that, in general, all E-C differences were small. A discussion section presents comparisons between the groups and seven recommendations for further endeavors. Also appended are forms used in the Experimental unit and counselor questionnaire responses. (Author/MS)

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TEXAS REHABILITATION COMMISSION

PROJECT EXPEDITE

An Investigation of Accelerated and Diagnostic Services In a Local Vocational Rehabilitation Office

AUGUST 1975

FINAL REPORT: GRANT NO. 12-P-55404/6

ACCELERATION AND EXPANSION OF THE DIAGNOSTIC SERVICES PROJECT IN HOUSTON, TEXAS

A FINAL REPORT

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Grantee: TEXAS REHABILITATION COMMISSION
AUSTIN, TEXAS

Authors: M.H. GOLDSTON, JR., PROJECT ADMINISTRATOR
ROBERT J. HEFLEY, PROJECT COORDINATOR

JULY 1975

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Project Expedite owes its success to the initial encouragement of Texas Rehabilitation Commission Deputy Commissioner W. K. Harvey, Jr. As a former Regional Director of the Houston area, Mr. Harvey realized the problems caused by lengthy delays in the diagnostic evaluation of potential rehabilitation clients. When he became Deputy Commissioner, Mr. Harvey actively sought a solution to the dilemma.

In 1970, three TRC staff members, Charles Funk, Regional Director; Robert J. Hefley, Psychologist; and M. H. Goldston, Jr., Supervisor, wrote the proposal for a Research and Demonstration grant for Project Expedite. They were aided in this effort by Harold Viaille, Ph.D., Rehabilitation Services Administration, who acted as a consultant and provided guidance in the development of the proposal's design.

The Project was implemented under the supervision of Regional Director Larry Nelson who gave the program unstinting support.

Carol J. Whitcraft, Ph.D., and the Research Division of the Texas Rehabilitation Commission Central Office rendered invaluable assistance throughout the entire process of data collection, data reduction, data analyses and interpretation. Without the computerized capability of the Research Division, timely analyses would not have been possible.

MAJOR FINDINGS

FOR

REHABILITATION WORKERS

The Project Expedite Experimental Unit diagnostic team consisting of a counselor-coordinator, medical examiner, social evaluator, psychologist, work evaluator and medical transcriber, demonstrated the feasibility of short-term vocational evaluation for a broad spectrum of disabled clients. Speed and comprehensiveness of diagnosis were the two goals of the Unit. With the exception of medical specialists' examinations, the entire evaluation took place in a vocational rehabilitation office centrally located in a large city.

Three to five referrals a day could be served. Each evaluation was customized to the person's individual needs. Complete evaluation within the Diagnostic Unit did not normally require more than two days and diagnostic packages were delivered to counselors in an average of eleven calendar days.

Approximately 53% of the E Unit referrals received work evaluation and approximately 73% received psychological evaluations.

The call-in system for reporting medical specialists' examinations was well-received by private physicians. Fifty per cent of the scheduled examinations were called in to the transcribing unit on the day of the examination.

Compared to a Control Group, the Experimental Group had almost an identical rate of rehabilitated case closures, but the Control Group had lower post-diagnostic service costs for training and, in general, required slightly less time to move cases from one phase to another. The Control Group also had fewer not-rehabilitated cases. In general, all E-C differences were small throughout the results.

An employment questionnaire mailed to rehabilitated clients indicated that the Experimental Group had better job stability.

Results from a counselor-user questionnaire indicated that the counselors endorsed the idea of receiving comprehensive diagnostic data in one package, as opposed to receiving reports one at a time.

Counselors who will use accelerated diagnostic units need specialized training to insure optimum results.

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I. DESCRIPTION OF PROJECT

The purpose of the Acceleration and Expansion of Diagnostic Services Project was to demonstrate the feasibility of and to research the effectiveness of providing faster, more relevant and more comprehensive diagnostic services to vocational rehabilitation clients who have a wide range of disabilities. The improved services were to be provided by an Experimental Unit and the results compared with those of a Control Unit.

Experimental Unit services were expected to produce (1) a reduction in the time required for diagnosis, (2) more accurate client appraisal, (3) a reduction in the rate of closures from referred status and (4) a substantial number of other positive changes in the planning, provision and final outcome of rehabilitation services. (A more detailed list of the hypotheses tested follows in Part VI).

II. DEFINITIONS

During the life of the Project, convenience brought about the substitution of several shorter names for the official Project title. These names included "Project Expedite", "Faster Services to Clients" and others.

Since terminology in this report can be confusing, the following definitions have been provided:

Project - This term encompasses the entire research and demonstration grant program, including both the experimental and control segments of the research design.

Experimental Unit - This refers to the organization of personnel and services providing innovative techniques of diagnosis. The letter E is frequently used as an abbreviation for the word "Experimental".

Experimental Group - Clientele receiving innovative techniques of diagnosis.

Control Unit - The organization of personnel and services providing traditional methods of diagnosis. The letter C is frequently used as an abbreviation for the word "Control".

Control Group - Clientele receiving traditional methods of diagnosis and serving as a comparative group for the Experimental Group.

III. GENERAL RATIONALE

A. Prompt Diagnosis as a Supportive Role to the Referral

The fundamental assumption underlying the justification for the Project was the belief that the diagnostic phase is not only basic to the provision of client services, but is critical to the development of a positive relationship between the applicant and the serving agency. It was felt that providing a warm receptive atmosphere and offering immediate attention to the diagnostic needs of the referral would engage and hold the person in the rehabilitation process better than the traditional method of obtaining diagnostic information a piece at a time with often lengthy lapses in continuity.

Although diagnosis is occasionally used as a useful tool of motivation to appraise the referral's stability and perseverance, this delay seemed inappropriate for clients with behavioral disorders as well as those with physical and mental disabilities. It was believed that any amount of motivation present in an individual could be reinforced through prompt attention. The entire thrust of Project activities was to achieve positive direction.

Project rationale was borrowed from the opinions of Rusalem and Baxt (1970)[1] who felt that current rehabilitation service delivery patterns were based on assumptions which were valid a generation ago. The fundamental assumption was that the employment-motivated, success-oriented disabled who could profit from rehabilitation services would be referred or find their way to a rehabilitation facility where they could enter a rehabilitation process consistent with their values, past experiences and present aspirations. Those who did not fit this description were considered to be "probably not ready for rehabilitation". In a day when rehabilitation was oriented to persons who introjected the dominant middle-class success values, this assumption had more validity than now. Because the social climate has changed greatly since the early days of rehabilitation, now more than ever, rehabilitation workers are charged with the task of trying to aid an increasing number of persons who in an earlier day would have been dismissed as uncooperative, infeasible or not ready for service. These persons - alienated, suspicious of organized middle-class controlled community services and resistant to the usual rehabilitation procedures that worked so well in the past - are a reminder that the service delivery pattern developed over the years may not be adequate today.

[1] Rusalem, Herbert and Baxt, Roland. Delivering Rehabilitation Services. Social and Rehabilitation Service, 1970 paper prepared for the use of delegates to the National Citizens Conference on the Disabled and Disadvantaged held in Washington, D.C.

Project Expedite was proposed as a unit to offer special attention and encouragement to the referral who, in addition to being disabled, is economically and psychologically ill-equipped to tolerate delays in service.

B. Comprehensiveness of Diagnosis

A second element in the rationale was the belief that faster diagnosis should be complemented with increased comprehensiveness. It was believed that a short-term type of work evaluation should be available to referrals to complement or substitute for psychological testing when the latter was not able to provide the desired vocational information. This belief stemmed from the observation of the coauthor of the Project proposal who worked as an agency psychologist from 1967 to 1970. He found that many applicants did not profit from psychological testing; i.e., either it had little or no predictive value for an applicant's area of work or it was inappropriate for the person's education or background. This was particularly true for many people who worked in manual labor or semiskilled jobs.

It was decided that a comprehensive diagnosis would be strengthened by the inclusion of a social worker type of interview that would include all areas of inquiry that could affect the person's rehabilitation. The comprehensive social interview and data gathering process was originally planned to include home visits as needed, but this aspect was largely eliminated as the Project progressed.

C. Relevancy of Diagnosis

The third aspect of the rationale pertained to relevancy of diagnostic procedures to the individual. It was planned to tailor each individual's diagnostic schedule to his personal needs, excluding any component of questionable relevancy. In other words, instead of sending referrals through a standard battery of procedures, each person would be carefully studied to make possible the formulation of an individualized schedule. This was planned not only to eliminate frustration and boredom on the part of the referral, but to speed up the overall procedure, thus saving time and money for both the client and the agency.

Shaping the diagnostic process to produce information highly relevant to vocational rehabilitation goals was a basic emphasis of the Experimental Unit (E Unit) from its beginning.

IV. RATIONALE FOR HOUSTON AS SITE OF PROJECT

Two considerations lay behind the choice of Houston as the site of the Project. First, Harris County's (Houston's) mean time in referral status (120 days) and mean time from acceptance to closure (156 days) both exceeded the statewide mean by 30 days. Secondly, due to the vastness of the Houston metropolitan area and the concentration of

counselors in one large office, referrals often had to come a long way to the office and then travel considerable distances to reach diagnosticians. The E Unit was proposed as a means of reducing this travel problem.

Due to the increasing interest in reaching disadvantaged and racial minority groups, it seemed essential that these groups be adequately represented in this demonstration Project. Fortunately, the Texas Rehabilitation Commission had a large office at 5619 Fannin Street which was in the proximity of two large poverty areas and had established a record of serving these groups. A 1970 survey of clientele processed at the main intake station in this office indicated a racial composition of 49% Black, 7% White with Spanish surname and 44% White. The survey showed that 10% were receiving some type of private or public assistance and that 54% were classified as disadvantaged by U.S. Manpower criteria.

V. PROCEDURES

A. Experimental Design and Client Selection

Project operations began at the 5619 Fannin Street office on November 15, 1972, and continued through December 31, 1974, a period of 25 1/2 months.

The simple experimental design called for Experimental (E) and Control (C) groups with random assignment of the subjects to the groups.

All referrals in both the E and C Groups were "walk-in" applicants with the exception of groups of alcoholics bussed in one day each week by a local skid row mission.

All subjects were drawn from four intake stations, each serving one of the four disability groups: physically disabled, alcoholics, mentally ill and mentally retarded. Table 4 shows the representation of each of these disability groups in the E and C Groups. Participation of the moderately or severely mentally retarded was minimal since these individuals did not adapt well to the general mode of operation of the E Unit. They did not tolerate short waits between diagnostic procedures very well and the E Unit's short-term work evaluation was not lengthy enough for a proper diagnosis.

The four interviewers in the 5619 Fannin Street office were instructed to keep a daily list of incoming clientele by recording the names in order of appearance. The interviewer then sent every other person to the E Unit, unless it was obvious that the person was totally inappropriate for referral; e.g., a person seeking welfare assistance, etc. The "every other one" system remained in effect from 11-15-72 until 5-7-74, at which time the system of selection was changed to an odd-even method based on the Social Security number. The E Unit received all referrals whose

Social Security numbers ended in an even figure, and the C Unit received the odd numbers. The new system, which worked well for the remainder of the Project, was adopted to insure the randomness of the sampling and make sure the E Unit did not receive more that its share of any disability group.

The following information describes the size of the E and C Groups used for comparative purposes:

	N of 02 Cases Seen	N of Invalid For Research	N of 02 Cases Remaining	N of Cases Closed as of 1-31-75 and Used in Research	% of Closed Cases
Experimental	1311	18*	1293	749	57.9%
Control	1282	-	1282	722	56.3%

*Most of these cases were found to be active cases on caseloads of various TRC counselors in the State.

B. Control Unit

Control referrals underwent diagnosis in the conventional manner. This meant that the referral was usually interviewed by a person classified as an "interviewer" which was below the personnel grade of a counselor. One of the interviewers could requisition psychological evaluations from an agency psychologist, but other than this, all diagnostic procedures had to be requisitioned from outside (private) diagnosticians. At the time of the initial interview, the interviewer was allowed to requisition the general medical examination and, under certain conditions, psychological and specialty evaluations. Generally, use of outside diagnosticians meant a wait of at least several days for an appointment and another more lengthy wait for the diagnostician's report to be prepared and returned by mail. Generally, new case records were delivered to counselors either when complete or within 15 days regardless of the amount of diagnostic material on hand.

C. Experimental Unit

In the planning and early implementation, the E Unit was characterized by a strict separation of diagnosis from the remainder of the rehabilitation process. Although a friendly, emphatic and helpful atmosphere prevailed in the Unit, seldom did integration of reports take place in the client's presence and counseling was limited to immediate problems of room and board, etc. In other words, no major decisions regarding remedial action took place during the diagnostic phase in the E Unit. These decisions were reserved for the permanent counselor, since it was believed that diagnosis would only require a short period of time, and the referral would see the permanent counselor relatively quickly. This policy prevailed in the Project until June 1974, at which

time it was modified in an effort to get the permanent counselor involved at the outset of the diagnostic process.

Usually referrals to the E Unit began the diagnostic process the day they were referred, but occasionally starting was postponed a day or two by request of the client or by the E Unit staff. A postponement occurred when the caseload became so great that it was necessary to momentarily restrict the influx of new referrals. Scheduling of client flow was an ever-present problem. If the volume of new referrals became excessive and remained so too long, case output would be hampered. Intake had to be carefully monitored to insure that the E Unit did not take so many referrals at once that it could not process them expeditiously.

On entering the E Unit, referrals were greeted by the receptionist and, usually within a matter of minutes, were shown a seven-minute audiovisual presentation which explained to them where they were, what the agency could do for them and how rapidly it could be accomplished. As soon as possible, usually no longer than 30 minutes, the referral was seen by either the service arranger (coordinator) or the social worker. The E Unit coordinator did most of the interviewing during the first year of the Project, but, as his responsibilities increased, the social worker began to share more and more of the interviewing duties. Since the social worker's educational background included a degree in vocational rehabilitation, she was competent to assume this role.

At the conclusion of the interview, an individualized schedule of diagnostic services was formulated by the interviewer. The schedule prescribed by the interviewer could be and often was altered easily by the Unit diagnosticians.

The schedule was recorded on a form termed a "routing sheet" (See Appendix, Exhibit A) which bore, in addition to the client's schedule, key client information. As the routing sheet preceded the client through the E Unit, each diagnostician added salient findings and "tips" for colleagues. This method of transmitting client information among various departments of the E Unit saved staff time and lowered client frustrations by reducing repetitious questioning of the client. Transfer of information by means of tape cassettes was tried, and, although the tape could be heard privately by headphones in the presence of the referral, the idea was abandoned in favor of traditional graphic methods.

During most of the project, those referrals needing psychological testing were usually seen first by the psychologist, provided he was not busy at the moment. If the psychologist was unavailable and the medical examiner was free, the referral was sent for a general medical examination. Occasionally the referral was seen first by work evaluation staff if this type of assessment was indicated, but generally work evaluation was the last service on the schedule. Since the psychologist would often obtain basic information pertaining to the person's stability and ability to read/write, both

work evaluation personnel and the medical examiner felt they could be more effective after this background information had been collected.

The referral usually completed his diagnostic schedule within the Unit in 1 1/2 - 2 days, although sometimes an extra day was required. If the referral needed medical specialty examinations, these had to be scheduled with outside physicians. Although the E Unit had no special privileges with medical specialists for getting clients early appointments, it did have the benefit of the call-in transcription system which allowed specialists to call in reports instead of using the traditional mail-in method. The results and advantages of this system are described in section E under "Medical Transcription".

As the diagnostic reports were typed within the E Unit, they were directed to the Unit's coordinator. When all or nearly all of the reports pertaining to a single individual had been received, the case was delivered to the counselor in the building who had been assigned the case. On the average, cases were forwarded to the counselor within 11 calendar days.

Cases were normally in referral status when they were delivered to the counselors. However, in the last six months of the Project, E Unit staff attempted to speed up the acceptance of certain cases by offering to do the paper work necessary to advance the case to acceptance status. This move was made simultaneously with the assignment of one counselor in each of the four disability areas to serve cases processed through the E Unit. This was another effort to speed up the rehabilitation process following diagnosis. Unfortunately, detailed results from a large number of cases processed during the last six months of the Project are not reflected in this research, since research data includes only those cases closed by January 31, 1975. This cutoff date was necessary in order for work to begin on the final report.

The function and activities of individual E Unit components will be discussed in part E of this section.

D. Experimental Unit Administration

Project Director

The Director was the Texas Rehabilitation Commission Region IV Director. Region IV includes most of Harris County and the city of Houston. It is one of seven TRC regions in the State. The Director's obligation was to assume the overall responsibility for the Project and approve all major decisions.

Project Administrator

The Administrator was responsible for the day to day management of the E Unit and the research component of the Project.

Project Coordinator

The Coordinator (also called the service arranger) was in charge of incoming referrals and outgoing case records. He served as backup person to the Administrator when the latter was absent. He also shared the responsibility for the research function of the Project.

E. Experimental Unit Components

Audiovisual Orientation

In order to orient new referrals, the E Unit showed each incoming applicant a seven-minute audiovisual presentation (35 mm color slides with sound) prepared by the Instructional Media Department of the Texas Rehabilitation Commission Central Office. In addition to instilling some conception of the sequence of events in the rehabilitation process, the presentation acquainted the applicant with his role and responsibilities. The rationale for this component centered around the need for having available for referrals a uniform, quality orientation with as high an instruction potential as possible. It was hoped that maximum effectiveness could be achieved by utilizing a combination of aural and visual stimuli. The audiovisual presentation was not designed to substitute for the friendliness and warmth of the one-to-one counselor-client relationship. The purpose of the orientation was to provide the referral with an objective, overall view of the Unit and the Agency in general, in hopes that the referral would manifest an increased motivation for rehabilitation.

Since our only method of checking the effectiveness of this program component was to ask referrals how they liked it and other similar questions, we queried them periodically and always obtained the same answers. "Yes, we liked it" or "Oh, it was fine" were typical responses. To say the least, much time and consideration were given to the preparation of the script. This was followed by professional assistance in recording the audio portion of the orientation. All in all, the presentation appeared to have very good face validity.

VR-Oriented Social Evaluation Interview

At the inception of the E Unit, a social worker was hired to assume the responsibility for this component. Her interviewing focused more upon the client's recent history and current situation than on the referral's remote past. The interview typically covered the following topics: family background, present living situation, military history, drug/alcohol abuse, psychiatric history, penal history, vocational training and vocational interests.*

*Appendix, Exhibits B and C are samples of the original and revised social evaluation report forms which the social worker or service arranger used to record findings for the case files.

Originally it was planned that the social worker would occasionally make home visits, but it was found that they were seldom productive. The client's verbal description of his home/neighborhood environment was adequate for planning during the diagnostic phase of the VR process. The social worker was found to be quite helpful in counseling clients with pressing financial and personal problems which precluded immediate involvement in the VR process.

About midway through the term of the Project, it became apparent that one service arranger (intake counselor) was not enough to sustain the desired level of applicant intake. Accordingly, the social worker position was converted to a service arranger position and both service arrangers added a condensed social evaluation component to the interview format they had been using.

Psychological Testing

Original plans for the provision of psychological testing in the E Unit worked out very well with only minor modifications in staffing. At the outset, it was believed that rapid testing of three to four applicants a day over an extended period of time would require two staff psychologists. We found, however, that with individualized "prescription" diagnosis, many testing situations could be abbreviated and the work load could be handled by one psychologist, provided the person was inclined toward a rapid mode of operation. We were fortunate to attract two Ed.D.s' (in succession), both of whom had talent for working in such a situation. With the assistance of a capable secretary, they were able to establish a good rapport with the applicants, administer the tests and dictate the reports within three days. In the case of abbreviated test batteries, reports were often available in one or two days.

The E Unit psychologist first talked briefly with the applicant and examined any background information that had been given to him by other Unit evaluators. This psychologist then made a tentative decision about the amount of testing needed and, as the test results were available, made necessary modifications to insure a personalized schedule of testing for the individual.

A common testing situation involved a paper and pencil I.Q. test, an achievement test such as the Wide Range, a test of organicity such as the Bender Motor Gestalt Test, a major personality inventory such as the MMPI and an interest inventory like the Kuder OIS or Minnesota Vocational Interest Inventory. In a few cases, testing could be reduced to only one or two tests. Use of individually administered tests (such as the Wechsler) was more the exception than the rule. The psychologist administered only the number of tests that would enable him to answer important questions associated with the case.

The psychologists had at least three testing booths available at the beginning of the day and a fourth booth could be put into use when necessary. Most of the testing was done on an individual

basis, since the faster service technique did not lend itself to group testing.

As planned, psychological reports contained an emphasis on vocational matters but care was taken not to overload the reports with this focus at the expense of other information needed by the counselor.

Nearly three out of four people receiving services in the E Unit received some degree of psychological testing.

During the 25 1/2 months of Unit operation, psychological testing for 995 clients cost approximately $51,047. The mean cost was $51.30. Costs were based on the factors shown below:

Salaries for psychologist and secretary (including fringe benefits)	$41,830
Rental cost of 773 sq. ft. space (office and testing booths)	$ 7,687
Expendable supplies (estimated @ $60 per month)	$ 1,530
	$51,047

In summary, psychological testing in the E Unit was carried out with an inherent advantage over a normal setting. The availability and free interchange of client information gave the examiner a better opportunity to do minimal testing by reducing the attending temptation to overbuy when ordering the testing. A possible disadvantage of the rapid mode of testing in the E Unit was the inability of the psychologist to use group testing with all the advantages that method offers. The matter of how long testing of a client can be delayed in order to form groups is a decision that each diagnostic unit must decide for itself. On the one hand, efficiency in testing can be gained, but on the other hand, there is the possibility of losing clients through delay.

Short-Term Work Evaluation

The short-term work evaluation component of the E Unit was designed to provide applicants a brief evaluation with work samples or other instruments having a closer resemblance to real work situations than standard psychological tests. Traditionally, work evaluation has been from two to eight weeks in duration and associated primarily with the mentally retarded and severely disabled. It was the intention of the E Unit's planners to offer for the first time (as far as they knew) an abbreviated form of work evaluation to the average "man on the street" VR referral. Since it is well-known that psychological tests are often saturated with verbal factors, the E Unit wanted to offer substitute or supplementary testing minimizing the presence of these factors. It was felt that this type of testing would increase the motivation of the applicant to take active

interest in his/her evaluation.

When the E Unit opened on November 15, 1972, development of the work evaluation section was only one-third finished and approximately four additional months were required for completion. A 1,100 square foot central area in the rear of the E Unit housed the work samples and other assessment devices. Two large glass windows separated the two work evaluators' offices from the central area, allowing them to observe client activity when it was necessary that they be in their offices. An additional regular-sized office was available for administering tests which required timing or a very quiet environment. The privacy of this room was also utilized for the showing of occupational information audiovisual presentations.

The work evaluation unit was originally staffed by an evaluator with an M.A. degree in vocational rehabilitation with specialization in work evaluation and an assistant who had received practical training in a large work evaluation unit. When the assistant resigned to enter college, she was replaced by another evaluator with an educational background identical to that of the first evaluator. Gradually, it became clear that E Unit client intake required no more than one and one-half evaluators, so this particular department of the E Unit was opened to referrals from other vocational rehabilitation offices in the city. Since these extra cases came from offices located distantly from the 5619 Fannin Street location, there was no danger of contaminating the research.

The E Unit's system of short-term work evaluation was eclectic in nature. Its repertoire included 16 standardized aptitude tests such as the General Aptitude Test Battery, Nursing Aptitude Tests, etc.; 6 standardized dexterity tests; 3 nonstandardized dexterity tests constructed from models devised in university training centers; 12 specific work samples such as a two-arm tracer to check coordination, a sorter, measuring exercises, etc.; general information testing situations such as the use of the Occupational Outlook Handbook, use of job application forms, etc. and an audiovisual section consisting of approximately 35 filmstrips and 15 slide-sound presentations. Each audiovisual gave a description of an occupation and varied in length from five to thirty minutes.

Of all the above techniques, the audiovisual presentations were believed to be among the least effective. It was planned that the audiovisual presentations of occupational information would be used in two ways: first, to offer the applicant realistic information about an occupation in which he/she might be interested and secondly, to permit exploration of unfamiliar work possibilities with the applicant. It was also planned to occasionally use the audiovisuals to dissuade applicants manifesting a strong interest in a type of work for which they were obviously unqualified. It was the opinion of the work evaluators that the audiovisual presentations did not seem to hold the applicants' attention, or, if they did, they did not seem to make strong impressions. In other words,

applicants did not seem to significantly change their perceptions of areas of work as a result of viewing the materials.

Applicants entering the short-term work evaluation section were briefly interviewed and areas of experience and interest were discussed with the evaluator. If no significant areas of interest became apparent at this point, the evaluator would often offer the applicant the opportunity to look through the Occupational Outlook Handbook in search of appealing jobs. This seemed to be fairly effective in most cases. All applicants, unless they were totally illiterate, were tested on their ability to complete a typical job application form. After these preliminary steps, the evaluation could follow many avenues in regard to the types of tests used. The applicant could usually complete the short-term work evaluation in 4-8 hours of actual applied time.

Work evaluation reports varied in length from 1-3 pages and their content centered around three areas: test results, clinical observations of work behavior and specific recommendations.

With applicants coming in at all hours of the day, it was often necessary that they return the following day (or at other scheduled times) to complete the evaluation. Despite the fact that the referral was being offered an excellent opportunity (by our values) to learn something about his abilities in a very short period of time, the following tabulation shows that 8% or 1 out of 12 of the referrals routed to the work evaluation unit did not return to complete the evaluation. Even in dropout cases, the work evaluator submitted as complete a report as possible with the available information. The tabulation below also reflects all work evaluation activity in the E Unit from 11-15-72 through 12-31-75.

Total N Seen By Work Evaluation	N of Cases From Outside Offices Served	N of Experimental Cases Served	N of Dropouts During Work Evaluation	% of Dropours
753	61	692	60*	8%

N of Referrals Completing Work Evaluation
693

*four cases were from outside offices

The following tabulation provides further information regarding dropouts. It describes the 1-31-75 closure statuses of 149 dropouts from all components of the E Unit and the 6-5-75 closure statuses of 60 dropouts from the work evaluation section. Since these status checks were made approximately 4 months apart,

it is suggested that the reader view the data from a descriptive rather than a comparative standpoint:

	08	%	26	%	28	%	30	%	OPEN	%
149 total dropouts from E Unit	85	57	7	5	9	6	2	1	46	31
60 dropouts from work evaluation	30	50	9	15	8	13	1	2	12	20

In approximately one-half of the dropout cases, the counselors were able to reestablish contact with the referral and proceed with the case. In other words, a dropout from the E Unit was not an automatic Status 08 closure.

In an effort to illuminate the effect of work evaluation on the final outcome of cases, the following tabulation describes the closure statuses of the 321 E Unit referrals to the work evaluation unit closed as of 1-31-75 and of 61 cases which had been referred to the work evaluation section from outside offices. Once again; since the two status checks were separated by four months, the reader is urged to view the tabulation only from a descriptive standpoint:

Results of Cases Served by Work Evaluation Component

	08	%	26	%	28	%	30	%	OPEN	%
Statuses of 321 E Unit cases as of 1-31-75	137	43	114	36	53	16	17	5	0	-
Statuses of 61 outside office cases as of 6-5-75	9	15	16	26	2	3	0	-	34	56

Slightly more than one out of every two E Unit referrals (692 out of a 1,311 total) were considered in need of work evaluation by the intake counselors (service arrangers).

During the last year of the Project, the work evaluation unit manned by two evaluators had a weekly intake of between 8 and 13 referrals. Due to the newness of the service and intake limitations imposed by the experimental design, the Unit was not able to reach what was believed to be its maximum intake/output. We believe that an experienced work evaluator, familiar with the samples and mode of operation in an established unit, could evaluate 6-8 people per week and prepare their reports. If prolonged work at such a pace created a fatigue problem, adjustments in work assignments might be necessary.

During the 25 1/2 months of E Unit operation, work evaluation for

753 clients cost approximately $86,239, with a mean cost of $114.52. Costs were based on the factors shown below:

Salaries for evaluators and secretary (including fringe benefits)	$68,873
1593 sq. ft. space (office and testing areas)	$15,836
Expendable supplies (estimated @ $60 per month)	$ 1,530
	$86,239

Operating under experimental conditions, the work evaluation unit had intake limitations in certain offices. In addition, throughout the term of the Project, but especially at the outset, the evaluators had to spend considerable time in planning, implementing and evaluating techniques. Under normal conditions, with an established system of testing, it is estimated that the cost of short-term work evaluation would be at least 10% below the above figure.

One of the questions that could quite logically be asked about short-term work evaluation concerns its ability to predict long-term work behavior patterns.

The short testing was usually long enough to permit a substantial amount of behavioral observation, but in many psychiatric cases involving erratic behavior it was difficult to make (with assurance) long-term work predictions from the 4-8 hour testing period.

On the other hand, there appear to be certain advantages in short-term work evaluation. First, the short testing period does not exhaust the referral and the person can work at his top potential. Secondly, short-term evaluation, based on the multiple sources of information of the team approach, should produce reports with reasonable accuracy of description and prediction. It would seem, though, that the short-term work evaluation report could be utilized quite well by the counselor if it were supplemented with behavioral information from other sources. Another positive aspect of short-term work evaluation is that the brevity of testing should have appeal to a number of people who could not or would not consent to long-term evaluation.

Faster General Medical Examination

The provision of space and basic office equipment for general medical examinations within the E Unit proved to be quite profitable. Besides the speed and convenience it afforded, there was another benefit. Early access to basic medical information made it possible for the work evaluator and psychologist to render reports with more specific recommendations.

The 20-30 minute basic medical examinations were performed by a private physician who served our office three afternoons a week

on a fee basis. During the early months of the E Unit, the doctor came to the office each day, but this was later changed to three afternoons a week, which proved to be adequate. The office was furnished with standard equipment consisting of an examining table, blood pressure unit, stethoscope, otoscope, ophthalmoscope and reflex hammer. The standard basic medical examination provided for a test for venereal disease at the discretion of the examiner. Any blood samples obtained were stored in a refrigerator and delivered to the city health department every 2-3 days for testing. Fortunately, our examination office had attached to it a small private bathroom which served as a lab for testing urine samples.

During the course of the Project, two general practitioners (in succession) served the E Unit. Both physicians had experienced some disability and had reshaped their practice to include only diagnostic work for specific businesses or agencies.

As a rule, the doctor examined three or four applicants in an afternoon, but he could easily see one or two more when necessary.

The physician's reports were handwritten on a standard Texas Rehabilitation Commission form and were available immediately after the examination. Before the Project ended, the E Unit medical examiner had been provided with another examining room in one of TRC's large outer offices. At the time of this report, there are four such offices in the Houston area.

Medical Transcription Component

The overall plan for expediting client diagnosis included an attack upon one of the traditional delays, the inordinate amount of time required to obtain medical specialty examination reports from physicians. While it was felt that we could not influence the amount of time required to secure appointments from medical specialists, it was believed that we could substantially reduce the reporting time following examination. We proposed to solve the reporting time problem by offering physicians the opportunity to call in examination results instead of using written reports. Early in the planning of the Project, a poll of a sample of medical specialists in Houston indicated that a large majority endorsed the idea of call-in reports.

A transcription unit capable of storing up to two hours of dictation was purchased and connected to a private telephone line in the E Unit. The telephone number assigned to the unit was sent to the physicians who had agreed to help pioneer the system. Each time an appointment was made with a specialist, he was sent a letter which reminded him of the special telephone number and the procedures to be used for call-in reporting. (See Appendix, Exhibit D). One of the most attractive features of the call-in system was its 24-hour-a-day availability. Many times physicians would dictate from their homes in the evening. When the dictation was transcribed, a copy of the unsigned report was immediately placed

in the client file and the original copy was mailed to the physician for his signature. In this manner, we had immediate use of the information while awaiting return of the official copy by the physician. Once received, the signed copy replaced the unsigned copy in the client file. Obviously, this type of operation requires an accurate and dependable medical transcriber. We were fortunate to have a very conscientious person in the E Unit who was able to carry out the assignment in an excellent manner. Although her experience was limited to regular TRC secretarial work when she first transferred to the E Unit, she worked hard to improve her medical vocabulary and became quite proficient within 12-15 months.

Based on a 25% sample (n=135) of a total of 546 examinations, the mean and median number of days from examination to call-in was examined. The effectiveness of the system is reflected in a mean of only 3 days from examination to call-in and a median of 0 or 1 days, depending on how the figures are interpreted statistically. The median of 0 or 1 means that at least 50% of the reports were called in on the day of the examination.

Approximately one out of every 12 reports was a two-part report which extended the reporting time to an average of 28 days or a median of 21 days. Such reports occurred in cases involving X-ray and laboratory studies which could not be done in the physician's office. It is inevitable that a certain number of these will occur.

Since we almost never scheduled specialty examinations to be reported by letter, we cannot offer any comparative statistics, but it would hardly be likely that the traditional written report system could produce comparable results.

The time from scheduling of the exam to the exam itself varied from approximately 1 to 14 calendar days with an estimated average of 7 calendar days or slightly less.

The slow response of doctors to requests for medical history data on present and past patients applying for VR services is a barrier to prompt diagnosis. The E Unit prompted deliberation on ways the telephone transcription system could be used to attack this problem. After about six months of operation, it was decided to give physicians the option of submitting their reports by the call-in method or using the traditional mail-in method. The results of this experiment are provided below.

Estimated N of optional letters to physicians	Estimated N Not replying	Estimated N replying	Estimated N replying by letter	N replying by call-in
990	247 - 25%	743 - 75%	585 - 79%	158 - 21%

Using a 25% sample (40 cases) of the 158 call-in reports, the time required to obtain such reports was investigated. The findings were as follows:

Full Calendar Days to Receive Called-In Reports

	N	%
2-10 days	19	48
11-20 days	7	17
21-50 days	9	23
51-100 days	4	10
101-115 days	1	2
Total	40	100

Mean = 21 days
Median = 12 days

The mean and median number of full calendar days used by physicians and institutions providing medical history data by letter were 21 and 23 days respectively. These statistics were derived from a 15% sample (n=202) of a total of 1300 reports.

Our medical history request to physicians and institutions did not include an offer to pay for the service. Whether payment would have made a difference in the speed of response is a matter of speculation. The need for a consistent policy did not allow us to experiment by offering one group a fee and none to another. We did pay a small fee on rare occasions when records would not be sent without payment.

In another call-in experiment, an arrangement was made between the E Unit and a private physician. The physician was paid a small fee to call in medical history reports from the local city-county hospital. It was often difficult to locate the hospital's records on active patients. Although the doctor checked medical records frequently, he often had to wait days before having the case in his possession. Data on the time required to obtain 51 call-in reports of this type are provided below.

Calendar Days Between Request and Call-In

	N	%
1-5 days	22	43
6-10 days	18	35
11-15 days	6	12
over 15 days	5	10
Total	51	100

Mean = 6 days
Median = 8 days
Range = 2 to 26 days

One advantage of the fee-paid call-in system for obtaining city-county hospital records was that the physician called in a summarized medical history of a page or less extracted from patient files which not infrequently contained 50-75 pages. When this information reached the counselor, via the call-in transcription unit, it was summarized, comprehensible and required little or no medical consultation for interpretation. In addition, the call-in physician often made recommendations for further examinations or treatment when he thought conditions warranted such action. Obviously this method of obtaining information from medical records saves much time and greatly simplifies use of the data by nonmedical personnel.

In summary, we found the call-in system very effective in reducing the time required to receive medical reports. In implementing a system of this type, it is most important to have a close working relationship with the reporting physicians. It is also very important to hire a competent medical transcriber.

The unit cost of 775 call-in reports was based solely on the transcriber's time (salary) spent in actual transcription work. The unit cost was approximately $10.00. Working under experimental conditions made it necessary for the transcriber to spend approximately 50% of her time in training and ancillary duties (keeping records, communicating with participating physicians and other tasks).

Transportation

Early planning for the E Unit included the proposed use of a van-type vehicle for transporting Unit referrals between the Unit and medical specialists' examinations. For two reasons this idea was abandoned in favor of supplying referrals with bus tokens when necessary. First, it was feared that the vehicle would not be used often enough to justify the expenditures involved. Secondly, a massive office decentralization program was underway which would place the Project office close to the residences of clients being served so that transportation would not be a major problem. It soon became apparent that the use of bus tokens worked satisfactorily. Thus, it was concluded that acquisition of a vehicle for the sole use of the E Unit could not be justified. It should be noted that bus tokens were available to Control applicants through their counselors, so this service was not an advantage restricted solely to E Unit referrals.

During the 25 months of the Project, bus tokens and transfers in the amount of $530 were issued. The following tabulation shows the E Unit's range of cost per issuance for the period November 15, 1972, to August 14, 1974.

Amount	Number of Issuances
$ .05 to .50	47
$ .51 to 1.00	266
$1.01 to 1.50	46
$1.51 to 2.00	67
$2.01 to 2.50	3
$2.51 to 3.00	5
$3.01 to 3.50	3

Mean issuance = $1.12
Mode = 51¢ to $1.00

VI. HYPOTHESES

It was hypothesized that the E Group would be found superior to the C Group on the following variables:

- Proportion of rehabilitated (Status 26) closures (See Table 7)
- Proportion of unsuccessful closures; i.e., Statuses 08, 28 and 30 (See Table 7)
- Poststatus 10 case cost (See Table 13)
- Time cases remained in diagnostic status; i.e., time required for Status 08 closure or acceptance (See Table 16)
- Time required to move Status 26, 28 and 30 closures from acceptance (declaration of eligibility) to closure (See Table 16)
- Percent of Status 26 closures requiring placement in follow-up status (See Table 17)
- Percent of cases requiring a change in vocational objective (See Table 17)
- Percent of cases placed in "Service Interrupted" category; i.e., Status 24 (See Table 17)
- Ratings of accuracy and usefulness of diagnostic information obtained from counselors by questionnaire (See Table 18)
- Indicators of client satisfaction with the diagnostic process (See Table 19)
- Indicators of postclosure employment stability of

- Status 26 closures from the client by questionnaire (See Table 19).
- Percent of repeat clients
- Suitability of plan objectives

Testing of the hypotheses pertaining to the number of repeat clients and suitability of plan objectives was found to be infeasible. The remaining hypotheses were tested using data from client files and responses to two questionnaires.

In order to obtain as much information as possible about the effects produced by the E Unit, the original research proposal was broadened to include studies of a number of variables besides those associated with the aforementioned hypotheses. These additional "performance" variables included: vocational rehabilitation closure, DOT classification and weekly earnings of Status 26 closures, diagnostic costs, expenditures for various types of training and closure statuses of Project cases maturing late and not included in the basic research study.

VII. RESULTS

During the period of Project operation, November 15, 1972, through December 31, 1974, 1,293 clients were served in the E Unit and 1,282 Control clients were given services in the traditional manner. The research component of the Project included 749 E and 722 C cases. These figures represent the total number of cases closed as of January 31, 1975, with the exception of a small number deleted from the research for technical reasons. Because of the time needed to locate the files in the various offices throughout Houston and extract the desired data, it was necessary to limit the primary focus of the research to these cases.

Although it was not possible to obtain complete research data on the cases remaining open on the January 31, 1975, cutoff date, Table 20 provides the vocational rehabilitation statuses of these cases as of June 19, 1975.

Data for the 749 E and 722 C subjects were recorded from client case folders. Data for each client was coded and keypunched on one computer card. Statistical procedures were performed using the "Statistical Package for the Social Sciences" (Nie et al, 1975[2]), adapted for Burroughs B4700 computer system by the Center for Computing and Information Management Service, Columbia University.

Data analyses included descriptive statistics for the E and C Groups and subgroups of each closure status within these groups. In addition, a number of cross-tabulations were produced.

[2]Nie, Norman H.; Hull, C. Hadlai; Jenkins, Jean G.; Steinbrenner, Karin and Bent, Dale. SPSS STATISTICAL PACKAGE FOR THE SOCIAL SCIENCES second edition. New York, NY: McGraw-Hill Book Company, 1975.

Chi-square (X^2) and Student's T were used to determine whether or not significant associations existed between variables and to determine the significance of differences between group means.

Computer analyses were not performed on data produced by the questionnaires.

All statistical computations and data reduction were performed by Research Division staff of the Texas Rehabilitation Commission's Central Office.

The variables selected for the research investigation were of two types, group comparability variables and performance or treatment variables. Group comparability analyses were necessary to be sure that the E and C Groups were equivalent on variables thought to be positively correlated with successful VR outcome. In other words, it was necessary to be sure that on the average both groups of clients were approximately equivalent in terms of case difficulty. The performance variables were chosen and labeled because it was felt they would reflect the performance of the two types of diagnosis or treatment.

* * *

Turning first to the results of group comparability studies, Tables 2 and 3 pertain to E and C Group comparability on the variables of age, education, race and sex. The degree of similarity on these variables is striking and differences were insignificant. The average client was approximately 35 years old and had 10 to 11 years of education. There were over twice as many Caucasians as nonCaucasians and one and one-half times as many males as females.

* * *

Table 4 permits comparison of the E and C Groups on the variable of primary disability. The disability assigned to a client depended upon the closure status. In the case of Status 08 closures (closed from referral status), the alleged disability at time of referral was generally used. In other types of closures, the diagnosed disability was assigned.

Comparisons of the representation of each disability type in the E and C Groups revealed no important differences. The two groups were strikingly similar on this variable. A few substantial differences were present, but their importance is undermined by small n's. The figures for orthopedic impairments involving 3 or more limbs are examples of this. The C percent is twice that of the E Group, but the n's involved are too small to attach much importance to this difference.

Noteworthy differences occurred in the psychotic and psychoneurotic categories; but it is felt that these differences are largely a function of differences in labeling practices of the E and C Units. The E Unit's intake staff and psychologist were reluctant to apply the psychotic label without considerable supportive evidence and tended to use the milder psychoneurotic and behavioral disorder labels. It is thought that the E Group suffered a small penalty by receiving slightly higher

percentages of two types of disability groups traditionally recognized as having very low rehabilitation success rates. The disabilities referred to are epilepsy and skid row alcoholics. Small differences in representation of disabilities of this type are probably more meaningful than would be the case with disabilities of lesser severity.

* * *

Table 5 describes the work status of the two groups at time of referral. The C Group had a slight advantage in the number of applicants employed at time of referral. It is a fairly well-accepted fact that employment at time of referral is one of the best known predictors of success in vocational rehabilitation.

* * *

Table 6 compares the groups on three variables:

(1) previous VR closure,
(2) public welfare status at time of referral and
(3) need for extended evaluation at time of referral.

The C Group had 2.2% more people who had been closed from VR rolls in the past 36 months, but whether this is an advantage or disadvantage is conjecture. It might be argued that for cases in which an old case file is available, the VR process can be accelerated. On the other hand, the position could be taken that recidivists are more difficult to rehabilitate.

Receipt of public assistance at time of referral appeared with identical frequency in the E and C Groups.

Since the need for extended evaluation is ordinarily an indication of case difficulty, this variable was included in the group comparability studies. The two groups were almost equal in terms of this variable with approximately 1 out of 50 referrals receiving such service.

* * *

Table 7 permits a comparison of VR closure results for the E and C Groups. Differences were quite small. The 2.9% fewer Status 08 closures in the E group may be represented in the 3.7% more E cases closed in Status 28.

* * *

Table 8 compares the success rates of the E and C Units for different types of disability. Substantial E-C differences were confined to the psychoneurotic and hearing impaired categories. The C Unit's rate of Status 08 closures was approximately one-half that of the E Unit for this disability group. In serving hearing impaired clients, the C Unit's rates of Status 26 and 08 closures were clearly superior to those of the E Group. The E Unit fared better in serving psychotic and internally physically handicapped clients, while the C Unit had greater

success with cases involving epilepsy and other neurological impairments and personality/behavior disorder cases.

* * *

Table 9 compares the E and C Groups on the reasons for closing cases in Status 08 from referral status. The differences between the groups appear to be small, with the largest being in the "unable to locate" category. In the nondisabled category, 2.7% more C Group cases were classified as not having a substantial disability. The C Group had 2.7% more cases closed in Status 08 because the handicap was too severe.

* * *

Table 10 shows the occupational classifications of the jobs of E and C Group rehabilitants at closure. The classification assigned was that corresponding to the first digit of the Dictionary of Occupational Titles code. Chi-square (X^2) was used to test for significance of association between group membership and specific occupational classifications. The results indicated a significant relationship ($X^2=14.20$, df=3, p=.003). The C Group had more placements in the professional, technical and managerial classes as well as in the service and processing categories. The E Group had more placements in the bench and structural work classes.

The investigators feel that a plausible explanation for this finding lies in the constant use of work evaluation with the E Group and the almost total absence of this service in the C Group. The primary focus of the work evaluation unit was upon blue collar types of employment. It is most likely that a high percentage of the clients who received work evaluation entered blue collar jobs.

* * *

Table 11 describes the weekly earnings of the E and C Group rehabilitants. While the C Group's weekly earnings mean was slightly higher than the E Group mean, the observed difference did not produce a statistically significant T value. It is interesting to note that the C Group contained more rehabilitants without earnings; i.e., homemakers and unpaid family workers.

* * *

Table 12 shows the total and mean cost of individual diagnostic procedures and all procedures combined for the two groups. In all four types of evaluation, the E Group had lower cost per diagnostic procedure. However, since a higher percentage of E referrals received the various procedures, the mean cost for the entire E Group was larger. The mean total diagnostic cost for the E Group was approximately two and one-half times that of the C Group. A little over one-third of this difference is due to the cost of the work evaluation procedure which was available only to the E Group. Other group differences are smaller but substantial. With the exception of medical specialty examinations, the differences

appear to be directly related to the fact that the E Unit had these procedures readily available for its incoming referrals.

A comparison of E and C Group Status 26 (rehabilitated) and Status 28 (not-rehabilitated) closures on mean and total cost of postdiagnostic services revealed that the C Group had a lower cost. Among 26 closures, the E Group had a total and mean cost of $116,283 and $731 for 159 clients with cost. For the 140 Status 26 closures from the C Group with cost, the total cost was $97,169 and the mean $694. The differences between the means were checked for significance using a T test; and the resulting T value was not significant.

The findings were the same among the not-rehabilitated. The E Group's total and mean costs for 71 clients with a cost were $29,022 and $409, respectively. The corresponding figures for the 47 C Group clients with cost are $17,484 and $372. The differences between these means were not statistically significant.

* * *

Table 13 provides data on the frequency with which individual post-diagnostic services were provided and the mean cost of each service for E and C rehabilitated (Status 26) and not-rehabilitated (Status 28) closures. While none of the differences between means were statistically significant in both the rehabilitated and not-rehabilitated subgroups, the E Group costs tended to be higher. The only exceptions were in expenditures for physical restoration and other services in the rehabilitated group. Regardless of case outcome, a greater percentage of the E Group received first training, maintenance and other services, while the C Group received physical restoration services at a slightly higher rate.

* * *

A detailed breakdown of "first training cost" for E and C rehabilitated and not-rehabilitated cases is presented in Table 14. The data there reveals that, regardless of VR outcome, more of the E clients received some type of training. As pointed out earlier, E-C differences in mean training costs were not statistically significant, although the average training expenditure for an E Group rehabilitant was approximately $100 higher than the expenditure for his C Group counterpart.

* * *

An analysis of the frequency with which various types of training were provided and the expenditures for each type are provided in Table 15. The statistics for the college or university category must be discounted due to the fact that at times it was impossible to discern whether college training was academic or vocational/technical.

The subgroup of rehabilitated clients provided the most salient finding in this analysis. There was a $200 difference between E and C Group's mean expenditure for business and trade school training. The E Group

received this type of training more often than the C Group. While halfway house placements occurred at the same rate, the C Group's mean cost was slightly higher. All other E-C differences were too small to be noteworthy.

* * *

Table 16 permits E-C comparison, by type of closure, of the time (days) required for clients to move from one phase of the VR process to the next. Group differences were small, but consistently favored the C Group with one exception. E Group rehabilitants were faster than their C counterparts in movement from referral to acceptance.

Differences between E and C means for Status 26 closures were checked for statistical significance with a T test, but in each case the null hypothesis prevailed.

For the Status 28 and 30 closures, X^2 tests were performed to determine whether a significant association existed between referral to closure time and E-C Group membership. These analyses produced nonsignificant X^2 values. While the results in Table 16 are not those expected, they are nonetheless informative.

* * *

Comparison of the E and C Groups on frequency of vocational objective change, placement in "Service Interrupted" status and need for follow-up services is provided in Table 17. These variables were selected for the research investigation because of their potential for reflecting the quality of the counseling provided the two groups. Inspection of Table 17 shows the two groups virtually tied on the vocational objective change variable and the C Group slightly superior on the "Services Interrupted" variable. Five percent fewer E clients received follow-up services of some type. The C percentage of clients receiving follow-up services was twice the E percentage; however, the impact of these figures is lessened by the relatively small number of clients involved.

* * *

Table 18 describes opinions of 20 counselor respondents who were the chief recipients of cases from the E Unit. Each responding counselor had received a minimum of six cases from the Unit. Since the E Unit was popularly known among the counselors as the "Diagnostic Unit", this phrase was used in the questionnaire. As a matter of definition, Diagnostic Unit cases can be equated with E Unit cases and Nondiagnostic Unit cases are the same as C Group cases.

Approximately one-half of the respondents thought they could work equally well with E and C cases. The other half of the counselors designated (by better than 2 to 1) E cases as their choice.

Ninety-five percent of the respondents expressed no problems in receiving so much information at once. On the other hand, 50% of the

respondents said they felt so "well-armed" with the comprehensive package of diagnostic information that they were tempted to accept cases they normally would not have accepted.

Nearly 90% of the respondents stated that they did not feel any obligation to accept E cases because they might be special in some way. A similar number of the respondents said they did not equate E cases with transfer cases from other counselors.

Ninety-five percent of the respondents ranked the psychological information, short-term work evaluation and the social history as 1 - 2 - 3, respectively, in priority of usefulness in counseling and deciding eligibility.

The 20 respondents were evenly divided in their opinions regarding whether E Unit operations created an atypical amount of unrealistic expectation in the E Unit clients assigned to them. Six of the ten counselors saying that the E cases did manifest unrealistic expectation stated this happened in only a few cases.

In the rating of psychological and work evaluation reports, all variables received a satisfactory rating by at least 50% of the respondents with readability and provision of vocational information ranking highest.

Ninety percent of the respondents stated that they preferred to receive diagnostic information as a package rather than one piece at a time. Sixty-five percent of the respondents said they would use a short-term work evaluation often if it were available.

Respondents' remarks to specific items on the questionnaire are listed in Exhibit E of the Appendix.

* * *

Tables 19(a), 19(b) and 19(c) describe the format and results of an Employment Questionnaire mailed May 15, 1975, to 151 E and 121 C clients who had been closed as employed (Status 26) during calendar year 1974 or January 1975. The 272 people to whom the questionnaire was sent represent all of the Project clients closed during the stated period except a few severe psychiatric and mentally retarded clients who were screened out for reasons of inability to respond. Care was taken to avoid biasing in favor of either group. The reply period remained open 21 days (May 15, 1975 - June 6, 1975). The primary purpose of the questionnaire was to compare the two groups on various aspects of employment stability.

The ideal E-C comparison would utilize data from all members of both groups; but, of course, this was not possible since direct access to all clients was no longer available. As described below, the percentage of questionnaires returned from both groups was almost identical and well above the level usually encountered in survey techniques not employing some type of reward for cooperation. Since data from both groups were obtained with the same sampling technique, the data may be assumed to

represent differences actually existing between the two groups. However, to insure the accuracy of this assumption, the data from both respondents and nonrespondents of each group were examined and analyzed, with no reason found to question validity.

Replies were received from 53 E and 43 C clients. Percentage of return for the E Group was 35.1% and 35.5% for the C Group. Two families of deceased E clients replied; but these were not counted as part of the experimental return. Thirteen questionnaires were received after the deadline; but, since the data from them did not alter the overall results, they were not included. The late returns did, however, officially increase the overall return to 40%. The Post Office returned 50 unopened questionnaires marked "not at this address", etc. If only the number of questionnaires actually received by the clients are considered, the overall percentage of the return within the 21-day deadline can be increased to 49%.

Table 19(a) is an example of a typical questionnaire as it was filled out and sent to the client. The most recent data were obtained from the client's case file in order to be as accurate as possible with the mail out.

Question #1 answers differentiated between two groups of respondents which are called Type A and B. Type A respondents consisted of 37 people who answered "yes" to question #1 indicating that they were still working at the same job (or company) that was last known to the VR counselor. Persons answering "yes" to question #1 were instructed to skip the remainder of the employment questionnaire and answer only the last two items (questions #7 and #8) which pertained to their perception of the speed and depth of their diagnostic experiences.

Type B respondents consisted of 57 people who answered "no" to question #1. This group was instructed to answer all the remaining employment questions plus the two perception items. Respondents, for reasons unknown, omitted answering some of the questions; and, as a result, the n for the various questions has small variations.

For the reader's convenience in interpreting the results of the questionnaire, Type A and B results are presented on two separate instruments, Tables 19(b) and 19(c), respectively. However, it should be made clear that only one questionnaire was mailed to the client.

As shown on Table 19(b), question #1, Type A respondents numbered 37 or 39% of the entire group of 94 people answering this question. The results show that the E Group had 11% more people who had successfully retained their job or company connection.

The replies of Type A respondents to questions #7 and #8 showed the E Group with a larger percentage of people perceiving their diagnostic assistance as beginning very quickly and a larger percentage thinking their problems were investigated very well.

The intermediate and low ratings had a very low n for both questions with only 14% of the E Group and 31% of the C Group falling in these

categories. The large percentage of ratings falling in the "very quickly" and "very well" categories were probably a manifestation of enthusiasm from Type A clients who were successfully employed and highly pleased with the efforts of Vocational Rehabilitation.

Table 19(c) provides a summary of the responses from Type B respondents who indicated in their replies to question #1 that they had not retained their jobs at closure or their connections with that company. Since the E Group had more Type A clients, it followed that they would have fewer Type B people. Twenty-nine or 56% of the 52 E clients were Type B, while 28 or 67% of 42 C Group respondents fell into the Type B category.

In question #2, the C Group had 12% more people stating they were still in the same line of work despite the fact that they did not have the same job or company connection as they did at closure.

The purpose of question #2a was to identify clients whose line of work periodically terminated because the job was completed and no further work was available; e.g., construction work. An examination of the data indicated that the question did not accomplish its purpose and the results are therefore largely invalid.

The results of question #3 revealed that the E and C groups had the same percentage of people who were working somewhere else. Both groups had 59% falling in this category.

Question #4 results indicated that 17% more E Group clients had done other kinds of work since leaving the jobs they held at closure.

As indicated in question #5 answers, 11% fewer of the E Group had had no employers since they left their jobs, but of those who had worked, 18% more of the E Group had only one employer. Of the E Group, 7% had had two or more employers, while 14% of the C Group fell in this category.

In question #6, each person was asked how much of the time since closure he had worked. This could vary from 5 to 17 months. The exact number of months for each individual was supplied in a blank space. The results indicated that the C Group had, on an average, worked 3% more of the time.

Question #7 answers regarding the client's perception of how fast his problem was investigated revealed that the two groups were almost evenly matched; but in question #8, the C Group was superior in 2 of the 3 ratings.

* * *

Table 20 makes possible a comparison of January 31, 1975, and June 19, 1975, case closure results for the E and C Groups. The June status check was of particular interest to the investigators as it was expected to reflect improvement in the E Unit's standing brought about by procedural changes made a year earlier. While the data shows that slight improvement did occur, admittedly there is no tangible evidence that it was a function of the procedural changes.

VIII. DISCUSSION

A. Experimental and Control Group Comparability

Viewing the Project from the standpoint of experimental design, the E and C Groups had good comparability on the variables of client age, education, race, sex, public assistance at referral and clients requiring extended evaluation following referral. However, two other variables may have operated together to give the C Group a slight advantage. First, the C Group had slightly fewer epileptic and skid row alcoholic cases, both of which are difficult to rehabilitate. Secondly, the C Group had more people employed at the time of referral.

Another factor that may have biased the experimental design slightly was client selection. Screening and routing of both E and C referrals was done by personnel outside the E Unit. Adjustments were necessary to insure a policy of what was correct for the experimental design rather than what was best for a particular referral situation.

B. Experimental Unit

Considering the E Unit separately, the various components worked well in the areas of speed, quality of service and implementation of innovative diagnostic procedures. After experiencing the usual problems associated with new organizations, the E Unit, in a reasonably short time, matured into a smoothly operating, highly goal-oriented diagnostic facility. The Unit accepted all types of referrals, from itinerants in town for only a few hours to the amputee needing repairs to his prosthesis; from applicants without food or shelter to those with less urgent needs. It provided quality diagnosis quickly and at a modest cost per procedure. Counselor-users rated the concept of faster, comprehensive, package-type diagnosis highly and, in general, endorsed the E Unit.

It did not take too long, however, to recognize that not all referrals were good candidates for rapid diagnosis. Some referrals did not have the mental stability to sustain the rapid pace while other referrals would quietly drop out without any apparent reason. Some referrals would state in advance that they could not spend one or two entire days in diagnosis and would request that the evaluation be spread out over a period of time. Although such cases were in the minority, E Unit evaluators had to be ever mindful of the possibility of dropouts.

C. Comparison of Experimental and Control Group Postdiagnostic Results

Results were varied with the E Group having slightly more rehabilitated closures than the C Group, but failing to produce the substantial increase that had been predicted. With one exception, case movement was slightly faster for the C Group than for the E Group. The exception was referral to acceptance for the E Group rehabilitated (Status 26) clients. The C Group had fewer not-rehabilitated (Status 28) clients

and postdiagnostic costs were generally lower. The C Group had fewer clients placed in interrupted status and had proportionally more people employed in "white collar" jobs with slightly higher earnings.

The E Group was superior in employment stability and required less follow-up than the C Group. The two findings seem related and appear to be the results of the faster, comprehensive diagnostic technique. Results of the counselor-user opinion questionnaire were generally favorable to the E Unit's method, performance and quality of diagnostic information.

Apart from the research findings, two other benefits may have resulted from the Project. The launching of the Project was, in a sense, a declaration to the community that the Texas Rehabilitation Commission was vitally interested in serving handicapped people promptly and that the agency would assist, cooperate and take whatever steps were necessary to accomplish this goal. The degree to which the Project may have been responsible is not known, but there are indications of improved diagnostic services in the Houston area. Although subject to further research, a second benefit may have resulted from the faster and comprehensive services. A sizable part of the E Unit Status 08 closures may have been referrals who resolved their own problems through the opportunity to learn and benefit from concentrated interaction with the various E Unit diagnosticians. In other words, the person may have taken action on his own and made little effort to further contact his counselor. A large sample of "closed from referral" status clients would have to be interviewed to affirm or negate this hypothesis.

Viewing the overall findings of the Project, it is apparent that the E Unit failed to produce the array of positive results predicted at the outset of the Project. E-C differences were seldom large and, from a statistical standpoint, the null hypothesis prevailed in the major areas of closure production, postdiagnostic costs and time required for case movement from phase to phase in the VR process.

A search for plausible explanations for the predominantly negative results produced a number of possible causes which can be classified as internal (emanating from within the E Unit itself) or external (emanating from outside the E Unit).

D. Internal Factors

Some observers of the Project's design, even before it began operation, criticized its use of surrogate counselors. They pointed out that early involvement of the permanent counselor would customize each case, both from the standpoint of the client's needs and the individual counselor's mode of operation; i.e., the counselor's unique method of case management including his repertoire of referral sources and counseling techniques. This point of view holds that by omitting the surrogate or "middle man", the client quickly becomes identified with his counselor in a relationship that is relatively free of third party opinion. Therefore, his case should progress more quickly and

economically. While recognizing that this factor could have played a role in the results, it should be pointed out that the C Group also used surrogates (interviewers) although to a lesser degree. Steps were taken in the latter months of the E Unit operation to involve the permanent counselor earlier in the rehabilitation process, but many of the cases served after these modifications were made had not sufficiently matured to be included in this report. Therefore, little is known regarding any changes brought about by the modifications.

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

E. External Factors

Several factors operating outside the E Unit are delineated for a better understanding of the experimental setting. The degree of effect on the results, if any, is not known. The order of listing does not necessarily reflect the importance of each factor:

(1) A citywide office expansion and decentralization process took place during the Project and resulted in numerous personnel transfers from the Project building. Often it was necessary to transfer counselors before they became accustomed to the system of faster diagnosis. This resulted in cases being transferred to a new or different counselor. The transfer of clients from one counselor to another may have had a neutralizing effect on the faster diagnosis coming out of the E Unit.

(2) The necessity of occasional fiscal austerity measures may have had a dampening effect on E referrals who had earlier been oriented to the idea of expeditious services.

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

(4) Faster diagnosis became available for the C Group when private psychologists established offices in the Project building and offered faster reporting services. One group of C Unit counselors had access to the services of an agency psychologist. These developments tended to reduce the advantages of the E Unit.

(5) Accustomed to having free access to all agency facilities to assist clients, some counselors may have found the research limitations imposed by random selection difficult to accept. In other words, counselors' attitudes may have been affected by the one-way flow of clients which permitted the E Unit to send them cases, but precluded counselors from referring cases to the Unit at their discretion.

While the aforementioned factors are important in understanding the Project's environment, they do not account for all the results by any means. In perusing the data, there seemed to emerge a pattern in the results that linked together a number of findings into a chain. The investigators believe that the starting force behind the sequence of events was the comprehensive E Unit diagnostic folder that was delivered to the counselor. This diagnostic package typically consisted of most or all of the following information:

detailed contact report
social evaluation
general medical examination
psychological information
work evaluation report
medical specialty reports
copies of letters requesting medical history information

Compared to a typical C Unit file, it was impressive and the size of the folder made it appear that the case had been in progress for several months.

The C Group case folder was processed more slowly. To accumulate a large folder usually required perseverance on the part of the referral. The waiting period allowed the counselor time to consider the case and to become better acquainted with the referral. In a sense, it also served as a test of motivation. Those persons who survived the waiting period usually were considered better candidates for successful rehabilitation.

In contrast to the traditional C Group procedures, the E Unit comprehensive diagnostic folders reached the counselors' desks rapidly. The individual counselor was faced with making decisions without many delays. The investigators believe that either the counselor felt an inclination to accept these cases due to all the effort that had gone into the diagnoses from both the referral and the E Unit (see question #2b remarks in Exhibit E) or the comprehensive folders tended to instill a degree of confidence in the counselor that blinded him somewhat to the actual difficulty of the case. In the counselor questionnaire (Table 18), 50% of the respondents stated "they felt so well-armed with the data that they were tempted to accept cases they might not ordinarily have accepted". As an added effect, referrals may have pressured their counselors or at least "pressure" was perceived by their counselors. In another part

of the counselor questionnaire, 50% of the counselors stated that at least some of the E Unit referrals had manifested an atypical amount of unrealistic expectation regarding the speed with which vocational rehabilitation services could be provided. If the aforementioned dynamics concerning case acceptance did occur, then one or both of the following things took place:

(1) The counselor felt more secure in the possibilities of rehabilitation and was willing to spend the time and money to see the case completed.

(2) The counselor encountered frequent case problems after acceptance and, in an effort to avert case failure, found it necessary to spend more money and keep the case file open longer. Furthermore, it would seem logical to assume that the more time, money and effort invested in a case, the slower the counselor would be to write it off as a loss. This would explain the unfavorable results of the E Unit, including the 2.2% higher rate of Status 28 (not-rehabilitated) cases (Table 20), the higher postdiagnostic cost of both rehabilitated (Status 26) and not-rehabilitated (Status 28) closures and the requirement of more time for acceptance and closure with one exception (Table 16)..

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

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

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

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

- Counselors who will be using faster diagnostic units need training in their use. They must understand the pitfalls so they can take counteractive measures.

- It must be recognized that faster diagnosis is not for everyone. It should be used selectively with proper screening procedures. In some cases, the referrals will screen themselves out by stating that they cannot spare the necessary time, etc.; but, in other cases, the screening depends on the skill of the person doing the interviewing. Unlikely candidates for faster diagnosis include certain mental

cases, severely mentally retarded referrals, many transients and the occasional inquirer who is "shopping among the agencies for the best deal".

- The referral's permanent counselor should be involved early in the case and be the one who decides what the pace of the diagnostic process should be and which procedures are needed.

- Since there is a tendency on the part of the referral to expect faster services following faster diagnosis, care should be taken to keep the two in balance. "Hurry up and wait" situations can be very frustrating to clients and should be avoided by proper planning.

- Faster diagnostic units can be used in many ways. Even in cases appearing to need extended evaluation, such a unit can quickly affirm or disaffirm a counselor's early judgments of the client. For some cases, the unit could be used by the counselor to obtain faster diagnostic increments; e.g., obtain a general medical examination report and base further diagnosis on the medical data plus an additional interview with the client.

- The investigators recommend that the next test of the RIDAC concept be strictly demonstrative in character. Operating a diagnostic unit under the limitations imposed by a research design can limit its effectiveness by creating an artificial atmosphere.

- The investigators believe that the small increase in employment stability shown by the Houston Diagnostic Unit was the product of comprehensiveness of its evaluation. It is felt that supplying the vocational rehabilitation counselor with more information about the client resulted in stronger job placements. Further RIDAC Units should not focus solely upon speed of assessment and fail to give due heed to the need for thoroughness.

APPENDIX A

TABLES

TABLE 1

Summary of Experimental Unit Activity
November 15, 1972 through December 31, 1974

Total served in E Unit	1693
N inappropriate for referral	226
N of 00 referrals	43
N of 02 referrals (received one or more services other than intake interview)	1311*
N of outside office cases (receiving one or more services)	113
Total N receiving one or more services other than interview (N of 02 referrals, 1311, plus N of outside office cases, 113)	1424
N receiving Psychological testing	995**
Percent of 1311 E Unit 02 referrals receiving Psychological testing	74%
N receiving Work Evaluation	753***
Percent of 1311 E Unit 02 referrals receiving Work Evaluation	53%
N receiving General Medical Examination	1198****
Percent of 1311 E Unit 02 referrals receiving General Medical Examination	89%
N of Medical Information Call-in transcriptions	775*****

*Virtually all these referrals received comprehensive social evaluation and were shown the seven minute slide-sound presentation.

**975 Exp. 02 referral cases plus 20 cases from outside offices.

***692 Exp. 02 referral cases plus 61 cases from outside offices.

****1171 Exp. 02 referral cases plus 27 cases from outside offices.

*****775 call-ins are subdivided as follows:

546 scheduled medical specialty exams called in. In approximately 12% of the cases there were more than one exam called in on the same person.

156 medical summaries of existing records called in by private physicians.

73 summaries of existing records at local city-county hospital called in by a physician retained by the E Unit on a fee-for-service basis.

Table 2

Age and Educational Attainment
of Experimental and Control Groups

Age	E Group (n=749) Frequency	E Group (n=749) Percent	C Group (n=722) Frequency	C Group (n=722) Percent
15 & below	0	0%	1	0%
16-25	251	33.5	214	29.6
26-35	177	23.6	193	26.7
36-45	159	21.3	138	19.1
46-55	117	15.6	131	18.1
56-65	41	5.5	38	5.3
66-75	3	0	5	1.0
76-85	1	0	0	0
Uncoded	0	0	2	0
Totals	749	100%	722	100%

Mean=34.10 Med.=32.19 S.D.=12.54 Range=16-76

Mean=34.81 Med.=32.10 S.D.=12.85 Range=15-74

Education	E Group (n=749)		C Group (n=722)	
0-6	52	6.9%	54	7.5%
7-9	142	18.9	131	18.1
10-12	406	54.2	382	52.9
13-16	117	15.6	125	17.3
17+	6	.8	5	.7
Special Ed.	26	3.5	24	3.3
Uncoded	0	0	1	.1
Totals	749	100%	722	100%

Mean=10.38 Med.=11.59 S.D.=2.85 Range=0-19

Mean=10.88 Med.=11.55 S.D.=4.29 Range=0-22

Table 3

Racial and Sexual Composition
of Experimental and Control Groups

	E Group (n=749)		C Group (n=722)	
	Frequency	Percent	Frequency	Percent
Race				
Caucasian	505	67.0%	499	69.1%
Non-Caucasian	244	32.6	222	30.7
Uncoded	0	0	1	.1
Totals	749	100%	722	100%
Sex				
Male	458	61%	432	60%
Female	291	39	290	40
Totals	749	100%	722	100%

Table 4.

Frequency Distribution of Disability
for Experimental and Control Groups

Disability	E Group (n=749) Frequency	E Group (n=749) Percent	C Group (n=722) Frequency	C Group (n=722) Percent
Visual impairment	3	0.3	1	0.1
Deaf	10	1.3	7	1.0
Hearing impaired	8	1.1	14	1.9
Orthoped. impt. 3 limbs or more	7	0.9	15	2.1
Orthoped. impt. 1 upper & 1 lower	9	1.2	11	1.5
Orthoped. impt. 1 or both upper	19	2.5	14	1.9
Orthoped. impt. 1 or both lower	35	4.7	35	4.8
Orthoped. impt. ill defined	46	6.1	49	6.8
Loss 1 upper and 1 lower or both upper	0	0	1	0.1
Loss 1 upper	1	0.1	2	0.3
Loss 1 or both lower	4	0.5	10	1.4
Loss other and unspecified part	1	0.1	0	0
Psychotic	42	5.6	95	13.2
Psychoneurotic	64	8.5	24	3.3
Alcoholism*	175	23.4	152	21.1
Drug addiction	9	1.2	3	0.4
Personality or behavior disorder	140	18.7	127	17.6
Mental retardation	31	4.1	21	2.9
Malignancies	2	0.2	1	0.1
Allergic, metabolic and endocrine	18	2.4	19	2.6
Blood disorder	2	0.2	2	0.3
Epilepsy & other neurological	41	5.5	26	3.6
Cardiac & circulatory	29	3.9	35	4.8
TB & other respiratory	8	1.1	8	1.1
Digestive disorder and hernia	8	1.1	11	1.5
Genito-urinary disorder	10	1.3	8	1.1
Speech disorder	3	0.4	4	0.6
Disability N.E.C.	19	2.5	20	2.8
Uncoded	5	0.6	7	0.9
Totals	749	100%	722	100%

*Included are 60 Experimental and 43 Control skidrow mission referrals. These frequencies represent respectively, 8 and 6 percent of the E and C groups.

Table 5

Work Status at Referral for Experimental and Control Groups

	E Group (n=749)		C Group (n=722)	
	Frequency	Percent	Frequency	Percent
Work Status				
Not Available	10	1.3%	10	1.4%
Labor Market	140	18.7	154	21.3
Sheltered Workshop	7	0.9	7	1.0
Self-employed	2	0.3	4	0.6
Homemaker	6	0.8	10	1.4
Student	9	1.2	6	0.8
Unemployed	573	76.5	529	73.3
Non-Compet. Labor	2	0.3	2	0.3
Total	749	100 %	722	100 %

Table 6

Miscellaneous Group Equivalence Comparisions

		E Group (n=749)		C Group (n=722)	
		Frequency	Percent	Frequency	Percent
VR Closure in Previous 36 Months					
	Uncoded	5	0.7	3	0.5
	Yes	103	13.8	113	16.0
	No	641	85.6	606	84.0
	Totals	749	100%	722	100%
On Public Assistance at Referral					
	Uncoded	6	1.0	5	1.0
	Yes	62	8.0	57	8.0
	No	681	91.0	660	91.0
	Totals	749	100%	722	100%
Placed in Extended Evaluation					
	Uncoded	8	1.0	18	2.5
	Yes	15	2.0	13	1.8
	No	726	97.0	691	95.7
	Totals	749	100%	722	100%

TABLE 7

VR Closure Status as of 1/31/75 for Experimental and Control Groups

	E Group		C Group	
	Frequency	Percent	Frequency	Percent
Closure Statuses				
08-Closed from Referral Status	350	46.7	358	49.6
26-Closed Employed	246	32.8	243	33.7
28-Closed Unemployed after Plan Initiated	119	15.9	88	12.2
30-Closed Before Plan Inititated	34	4.5	33	4.5
Total	749	100%	722	100%

TABLE 8

Crosstabulation of Disability Type and Closure Status
for Experimental and Control Groups

Disability	E Group Status 26 Freq	%	Status 28 Freq	%	Status 08 Freq	%	Status 30 Freq	%	Row Total	C Group Status 26 Freq	%	Status 28 Freq	%	Status 08 Freq	%	Status 30 Freq	%	Row Total
Visual impairment	1	33	0	0	2	67	0	0	3	0	0	0	0	1	100	0	0	1
Hearing disabilities	7	39	0	0	10	56	1	5	18	13	62	1	5	7	33	0	0	21
Orthopedic disabilities	40	33	15	12	62	51	5	4	122	45	33	12	9	75	55	5	3	137
Psychotic	9	21	4	10	28	67	1	2	42	13	14	8	8	71	75	3	3	95
Psychoneurotic	16	25	6	9	38	60	4	6	64	12	50	3	13	8	33	1	4	24
Alcoholism	67	38	52	30	53	30	3	2	175	63	41	37	24	51	34	1	1	152
Drug addiction	3	33	1	11	5	56	0	0	9	1	34	1	33	1	33	0	0	3
Personality or behavior disorder	48	35	16	11	65	46	11	8	140	56	44	17	13	45	36	9	7	127
Mental retardation	14	45	6	19	11	36	0	0	31	9	43	1	5	9	43	2	9	21
Internal* physical disabilities	24	31	6	8	41	53	6	8	77	16	19	4	5	57	68	7	8	84
Epilepsy & other neurological disorders	9	22	6	15	24	59	2	4	41	8	30	2	8	14	54	2	8	26
Speech disorder	0	0	0	0	3	100	0	0	3	1	25	0	0	3	75	0	0	4
Disability N.E.C.	7	37	6	32	5	26	1	5	19	5	25	1	5	11	55	3	15	20
Uncoded	1	20	1	20	3	60	0	0	5	1	14	1	14	5	72	0	0	7
	246		119		350		34		749	243		88		358		33		722

*This category includes hernias and malignancies as well as allergic, metabolic, endocrine, blood, cardiac & circulatory, TB & other respiratory, digestive, and genito-urinary disorders.

TABLE 9

Frequency Distribution of Reason for 08 Closure*
for Experimental and Control Groups

Closure Reason	E Group (n=350) Frequency	E Group (n=350) Percent	C Group (n=358) Frequency	C Group (n=358) Percent
Uncoded	11	3.1	10	2.8
1-Unable to locate	136	38.9	116	32.4
2-Handicap too severe	26	7.4	36	10.1
3-Refused services	75	21.4	76	21.2
4-Death	1	0.3	1	0.3
5-Institutionalized	0	0	4	1.1
6-Transferred agencies	2	0.6	1	0.3
7-Uncooperative	66	18.9	74	20.7
8-Nondisabled	15	4.3	25	7.0
9-No handicap	18	5.1	15	4.2
Total	350	100%	358	100%

*Closed from referral status.

TABLE 10

Occupational Classification* of Experimental and Control Group Rehabilitants (26 Closures)

	Occupational Class	E Group (N=246) Frequency	E Group (N=246) Percent	C Group (N=243) Frequency	C Group (N=243) Percent
1-0	Professional, technical & managerial	25	10.2	37	15.2
2	Clerical & sales work	61	24.8	56	23.0
3	Service work	47	19.1	56	23.0
4	Farming, fishery, forestry, etc.	2	0.8	8	3.3
5	Processing work	11	4.5	24	9.9
6	Machine trades	22	8.9	17	7.0
7	Bench work	17	6.9	8	3.3
8	Structural work	37	15.0	22	9.1
9	Misc.	24	9.8	15	6.2
	Totals	246	100%	243	100%

$X^2=14.20$, df=3, p=.003

*Reflected by first digit of DOT code assigned by counselor closing case.

TABLE 11

Weekly Earnings of Experimental and Control Group Rehabilitants (26 Closures)

Weekly Earnings	E Group (n=246) Frequency	E Group (n=246) Percent	C Group (n=243) Frequency	C Group (n=243) Percent
$0	11	4.5	19	7.8
$1-80	70	28.4	69	28.4
$81-160	138	56.1	118	48.5
$161-240	15	6.1	22	9.1
$241-320	6	2.4	4	1.6
$321+	2	0.8	3	1.2
Uncoded	4	1.6	8	3.3
Totals	246	100%	243	100%

Mean including cases with no earnings = $105.64 (n=242)

Mean cases with earnings only = $110.67 (n=231)

Range = $25-$325

Mean including cases with no earnings = $107.29 (n=235)

Mean cases with earnings only = $116.73 (n=216)

Range = $20-$882

TABLE 12

Diagnostic Costs of Experimental and Control Groups

	749 Experimental Cases					722 Control Cases				
	N Receiving Exam/Eval	Total Cost	% of Total Cost	Mean Cost Per Exam/Eval	Mean Cost 749 Referrals	N Receiving Exam/Eval	Total Cost	% of Total Cost	Mean Cost Per Exam/Eval	Mean Cost 722 Referrals
General Medical	679	$13,936	14%	$ 20.52	$18.60	375	$ 9,613	23%	$ 25.63	$13.31
Specialty Medical	314	24,329	23	77.48	32.48	156	13,835	34	88.68	19.16
Psychological	536*	28,932	28	53.97**	38.62	247	17,308	42	70.07	23.97
Work Evaluation	321	36,760	35	114.52***	49.08	3	355	1	118.33	-
TOTAL		$103,957	100%				$41,111	100%		
Mean Total Diagnostic Cost	-	-	-	-	$138.79	-	-	-	-	$56.94

*Includes 52 referrals tested by private psychologists.

**See psychological section under Procedures for explanation of how this cost was determined.

***See work evaluation section under Procedures for explanation of how this cost was determined.

TABLE 13

Cost of Post-diagnostic Services for Experimental and Control Group Rehabilitated and Not Rehabilitated Cases

REHABILITATED CASES-(26 CLOSURES)

	E Group (n=246)			C Group (n=243)		
Service	Number Receiving Service	Percent	Mean Cost for n Receiving Service	Number Receiving Service	Percent	Mean Cost for n Receiving Service
Training (First)*	108	43.9	$603.80	86	35.4	$492.74
Training (Second)*	4	1.6	828.25	6	2.5	800.48
Physical Restoration	59	24.0	348.54**	64	26.3	500.72**
Maintenance	67	27.2	300.36	46	18.9	262.26
Other	57	23.3	124.05	36	14.8	163.34

NON-REHABILITATED CASES-(28 CLOSURES)

	E Group (n=119)			C Group (n=88)		
Service	Number Receiving Service	Percent	Mean Cost of n Receiving Service	Number Receiving Service	Percent	Mean Cost of n Receiving Service
Training (First)*	51	42.9	$334.16	35	39.8	$320.46
Training (Second)*	3	2.5	265.01	0	0	0
Physical Restoration	25	21.0	199.88	22	25.0	190.18
Maintenance	25	21.0	146.68	13	14.8	114.53
Other	28	23.5	90.04	11	12.5	54.09

*A small number of clients were placed in two training programs.

**The C Group's mean physical restoration cost was inflated by one exceedingly high cost-$5545.00. Excluding this figure, the C Group range was $8-$2654. The E Group range was $20-$1796.

TABLE 14

Cost of First Training* for Experimental and Control Group
Rehabilitated and Not Rehabilitated Closures

	26 Closures (Rehabilitated)				28 Closures (Not Rehabilitated)			
	E Group		C Group		E Group		C Group	
	N	Percent	N	Percent	N	Percent	N	Percent
0 (No Training)	137	55.7	150	61.7	68	56.3	53	60.2
$1-300	40	16.3	31	12.8	25	21.0	20	22.7
301-600	26	10.6	27	11.1	18	15.1	10	11.4
601-900	17	6.9	19	7.8	6	5.0	4	4.5
901-1200	16	6.5	5	2.1	2	1.7	1	1.1
1201-1500	3	1.2	2	0.8	0	0	0	0
1501-1800	3	1.2	0	0	0	0	0	0
1801-2100	1	0.4	2	0.8	0	0	0	0
2101+	2	0.8	0	0	0	0	0	0
Uncoded	1	0.4	7	2.9	1	0.8	0	0
Total	246	100%	243	100%	119	100%	88	100%
Mean for all cases	$266.16 (n=245)		$179.56 (n=236)		$144.42 (n=118)		$127.45 (n=88)	
Mean for cost cases only	$603.80 (n=108)		$492.74 (n=86)		$334.16 (n=51)		$320.46 (n=35)	

* A small number of clients were placed in two training programs.

TABLE 15

Type of First Training* Received and Cost for Experimental and Control Rehabilitated and Not Rehabilitated Closures

Rehabilitated (Status 26) Closures

Type Training	N E Group	% E Group (n=246)	N C Group	% C Group (n=243)	E Total Cost	C Total Cost	E Mean	C Mean
No Training	138	56	157	64	$ 0	$ 0		
College or University	6	2	1	0	1,127	215	$ 188	$ 215**
Business or Trade School	63	26	48	20	43,638	22,764	693	474
On Job Training	0	0	2	1	0	2,131		1,066**
Halfway House	34	14	33	14	16,514	16,836	486	510
Other	3	1	2	1	3,672	430	1,224**	215**
Uncoded	2	1	0	0				
Total	246	100%	243	100%	$64,951	$42,376		

Not Rehabilitated (Status 28) Closures

Type Training	N E Group	% E Group (n=119)	N C Group	% C Group (n=88)	E Total Cost	C Total Cost	E Mean	C Mean
No Training	67	56	53	60	$ 0	$ 0		
College or University	1	1	1	2	58	45	$ 58**	$ 45**
Business or Trade School	14	12	9	10	6,163	3,979	474***	442
On Job Training	0	0	0	0	0	0		
Halfway House	35	29	25	28	10,567	7,192	302	288
Other	2	2	0	0	254	0	127**	
Total	119	100%	88	100%	$17,042	$11,216		

*Occasionally a client was placed in more than one training program.
**Based on a very small n.
***Training cost for one client in this category was unavailable, so this mean is based on n of 13.

TABLE 16

Time (Days) in VR Process for all Closure Types
for Experimental and Control Groups

CLOSED REHABILITATED
(Status 26)

Phase of VR Process	E Group (n=246) Mean		Range	C Group (n=243) Mean		Range
Referral to Acceptance	54.33	(n=244)	1-402	55.38	(n=236)	0-461
Acceptance to Closure	188.67	(n=244)	21-620	184.49	(n=236)	14-862
Referral to Closure	242.43		41-663	235.27		28-750

CLOSED NOT REHABILITATED AFTER PLAN INITIATED
(Status 28)

Phase of VR Process	E Group (n=119) Mean	Range	C Group (n=88) Mean		Range
Referral to Acceptance	47.79	0-318	42.82	(n=85)	0-325
Acceptance to Closure	231.35	10-583	223.81	(n=85)	6-666
Referral to Closure	279.17	23-654	266.22		8-739

CLOSED NOT REHABILITATED BEFORE PLAN INITIATED
(Status 30)

Phase of VR Process	E Group (n=34) Mean	Range	C Group (n=33) Mean		Range
Referral to Acceptance	77.21	24-270	65.83	(n=30)	8-217
Acceptance to Closure	184.47	8-450	177.07	(n=30)	32-489
Referral to Closure	263.15	55-503	232.09		48-546

CLOSED FROM REFERRAL STATUS
(Status 08)

Phase of VR Process	E Group (n=350) Mean	Range	C Group (n=358) Mean	Range
Referral to Closure	138.78	6-429	137.89	1-709

TABLE 17

Frequency of Vocational Objective Change, Placement in Status 24, and Follow-up Service for Experimental and Control Groups

	E Group (n=365)*		C Group (n=331)*	
	Frequency	Percent	Frequency	Percent
Vocational Objective Changed				
Yes	78	21.4	74	22.3
No	279	76.6	246	74.3
Uncoded	8	2.2	11	3.3
Totals	365	100%	331	100%

	E Group (n=365)*		C Group (n=331)*	
Placement in Status 24 - Service Interrupted				
Yes	55	15.1	36	10.9
No	302	82.7	285	86.1
Uncoded	8	2.2	10	3.0
Totals	365	100%	331	100%

	E Group (n=246)**		C Group (n=243)**	
Received Follow-up Services				
Light (counseling &/or placement)	9	3.7	17	7.0
Heavy (light + funds expended)	3	1.2	7	2.9
None	234	95.1	219	90.1
Totals	246	100%	243	100%

*Includes cases closed rehabilitated (status 26) and not-rehabilitated (status 28)
**Incluedes only cases closed rehabilitated (status 26)

TABLE 18

COUNSELOR OPINION QUESTIONNAIRE*

1. In terms of groups, think back over the clients that you received from the Diagnostic Unit versus those you received from other sources.

   (a) Which group was easier to work with? Check one:

Diagnostic Unit cases	7(37%)
Non-Diagnostic Unit cases	3(16%)
No difference	9(47%)

   (b) Which group, do you feel, showed the greatest motivation? Check one:

Diagnostic Unit cases	5(26%)
Non-Diagnostic Unit cases	2(11%)
No difference	12(63%)

2. (a) With Diagnostic Unit cases, did receiving so much information all at once cause you any problems?

   Check one:

Yes	1(5%)
No	19(95%)
No opinion	

   Comments_____

   (b) With Diagnostic Unit cases, did you feel so "well armed" by the comprehensive package of diagnostic information that you were tempted to accept (status 10) clients you normally would not have accepted?

   Check one:

Yes, often	2(10%)
Yes, sometimes	8(40%)
No	9(45%)
No opinion	1(5%)

   (c) Did you tend to feel any obligation to accept (status 10) Diagnostic Unit clients because they were "special" in some way, i.e., might be scrutinized later?

   Check one:

Yes	2(11%)
No	17(89%)

   Comments_____

*Questions 1 (a), 1 (b), 2 (c), 2 (d), 4 and 6 had 19 counselor responses instead of the 20 found elsewhere in the questionnaire.

(d) In your mind, did you tend to equate Diagnostic Unit cases with transfer cases coming to you from other counselors?

Check one:

Yes 2(11%)
No 17(89%)
No opinion _____

3. From its beginning, the Diagnostic Unit's intent was to remain strictly diagnostic and do a bare minimum of counseling, i.e., only as absolutely necessary. We felt this function should be reserved for the counselor receiving the case.

(a) Do you think this was a wise policy? Check one: Yes 19(95%) No 1(5%)

(b) How well do you think we lived up to this policy? Circle appropriate number on scale:

N= 2(10%) 5(25%) 13(65%)

1 — 2 — 3 — 4 — 5

Unsatisfactory — Satisfactory

4. While functioning, the Diagnostic Unit provided three types of non-medical information. Although it may be somewhat difficult, please rank them according to usefulness, giving equal weight to usefulness in counseling and usefulness in deciding eligibility.

	RANK			
	1st	2nd	3rd	No opinion
Social history	20%	25%	50%	5%
Psychological	60%	15%	20%	5%
Short-term work evaluation	20%	60%	15%	5%

5. In normal periods when case service monies were available, did the style of operation in the Diagnostic Unit seem to create an atypical amount of unrealistic expectations from clients about the speed with which VR services could be provided?

Check one: Yes 10(50%) No 10(50%)

If your answer is yes, check appropriate blank:

In a few cases 6(60%)
In a fair number 3(30%)
In a large number 1(10%)

6. Call to mind the psychological reports (as a group) you received from the Diagnostic Unit. Rate them on the following points by placing a ✓ in the appropriate box.

PSYCHOLOGICAL REPORTS

	Satisfactory	Unsatisfactory	No opinion
Readability	20(100%)		
Comprehensiveness	12(60%)	7(35%)	1(5%)
Prediction of client behavior	12(60%)	4(20%)	4(20%)
Provision of vocational information	15(79%)	4(21%)	
Accuracy of vocational predictions	11(55%)	4(20%)	5(25%)

7. In the same manner, rate the short-term work evaluation reports you received.

SHORT-TERM WORK EVALUATION REPORTS

	Satisfactory	Unsatisfactory	No opinion
Readability	20(100%)		
Comprehensiveness	16(80%)	4(20%)	
Provision of vocational information	18(90%)	2(10%)	
Accuracy of vocational predictions	10(50%)	5(25%)	5(25%)

8. In general, which system of diagnosis do you find more useful in working with VR clients? Check one:

18(90%) Receiving the diagnostic information all at once (or nearly complete)

2(10%) Receiving the diagnostic components a piece at a time

9. If you now had unlimited access to short-term work evaluation such as that provided by the Diagnostic Unit, how often would you use it? Check one:

Often 13(65%)
Occasionally 6(30%)
Seldom 1(9%)

(Please make any other general remarks that you wish on the back side of this page)

TABLE 19 (a)

(Example of typical questionnaire illustrating data supplied by researcher)

TEXAS REHABILITATION COMMISSION

E M P L O Y M E N T Q U E S T I O N N A I R E

Several months ago you were working as a welder at Ace Welding Company
Please bring us up to date by answering the questions below.

1. Are you still working at this same job or with the same company? Yes____ No____

   Note: If answer is yes, skip questions 2, 3, 4, 5, 6 and start with 7.

2. Are you still following welding as you line of work? Yes____ No____

   Does your line of work require you to go from job to job quite often? Yes____ No____

3. Are you working somewhere else now? Yes____ No____

4. Have you done other kinds of work since you left welding Yes____ No____

5. How many different employers have you had since leaving Ace Welding Company ?
   Show number here → _____ employers

6. How many months have you worked out of the last 16 months? _____ months

7. When you first came to our agency for help, which of the following words best describes how quickly we started to look into your problem? Check ✓ one of the following:

   ____Very quickly ____Fairly quickly ____Slowly

8. How well did we look into your problem? Check ✓ one of the following:

   ____Very well ____Fairly well ____Poorly

If you have any comments or wish to explain any of your answers, please write all you wish on the back side of this sheet.

TABLE 19 (b)

Data Results Received from 23 Experimental and 14 Control Type A Respondents*
TEXAS REHABILITATION COMMISSION

E M P L O Y M E N T Q U E S T I O N N A I R E

Several months ago you were working as a _____
Please bring us up to date by answering the questions below.

1. Are you still working at this same job or with the same company? Yes E=23(44%) C=14(33%) No_____.

Note: If answer is yes, skip questions 2, 3, 4, 5, 6 and start with 7.

Thirty seven or 39% of the total group of 94 respondents indicated that they were still working at the same job or with the same company. The E group had 23 or 44% of 52 people replying yes on this question, and the C group had 14 or 33% of 42 people replying in a similar manner.

7. When you first came to our agency for help, which of the following words best describes how quickly we started to look into your problem? Check ✓ one of the following:

E=20(86%) C=10(76%) Very quickly

E=2(9%) C=1(9%) Fairly quickly

E=1(5%) C=2(15%) Slowly

8. How well did we look into your problem? Check ✓ one of the following:

E=21(91%) C= 9(69%) Very well

E=2(9.0%) C=2(15.5%) Fairly well

E=0 C=2(15.5%) Poorly

If you have any comments or wish to explain any of your answers, please write all you wish on the back side of this sheet.

*Some respondents did not respond to every item in the questionnaire.

TABLE 19 (c)

Data Results Received from 29 Experimental and 28 Control Type B Respondents
TEXAS REHABILITATION COMMISSION

E M P L O Y M E N T Q U E S T I O N N A I R E

Several months ago you were working as a _____
Please bring us up to date by answering the questions below.

1. Are you still working at this same job or with the same company? Yes____ No E=29(56%) C=28(67%)
   Note: If answer is yes, skip questions 2, 3, 4, 5, 6 and start with 7.

2. Are you still following _____ as your line of work? Yes E=10(38%) C=11(46%) No E=23(88%) C=13(54%)

   Does your line of work require you to go from job to job quite often? Yes E= 3(12%) C= 6(25%) No E=23(88%) C=18(75%)

3. Are you working somewhere else now? Yes E=17(59%) C=16(59%) No E=12(41%) C=11(41%)

4. Have you done other kinds of work since you left _____ Yes E=15(54%) C=10(37%) No E=13(46%) C=17(63%)

5. How many different employers have you had since leaving _____?

   Show number here → _____ employers

	Experimental	Control
7=0	employers (25.0%)	10=0 employers (36.0%)
19=1	employer (68.0%)	14=1 employer (50.0%)
1=2	employers (3.5%)	3=2 employers (10.7%)
1=3	employers (3.5%)	1=3 employers (3.3%)

6. How many months have you worked out of the last __ months? _____ months

	Experimental	Control
Mean % of Mos. Worked	65%	68%

7. When you first came to our agency for help, which of the following words best describes how quickly we started to look into your problem? Check ✔ one of the following:

E=15(56%) C=15(54%) Very quickly
E=10(37%) C=11(39%) Fairly quickly
E=2(7%) C=2(7%) Slowly

8. How well did we look into your problem? Check ✔ one of the following:

E=15(56%) C=18(64%) Very well
E=7(26%) C=7(25%) Fairly well
E=5(18%) C=3(11%) Poorly

If you have any comments or wish to explain any of your answers, please write all you on the back side of this sheet.

TABLE 20

Comparison of 1/31/75 and 6/19/75 VR Closure Statuses
for Experimental and Control Groups

VR Closure Statuses as of 1/31/75 for Experimental and Control Groups

	E Group		C Group		
	Frequency	Percent	Frequency	Percent	% Difference
Closure Statuses					
08-Closed from Referral Status	350	46.7	358	49.6	2.9
26-Closed Employed	246	32.8	243	33.7	.9
28-Closed Unemployed after Plan Initiated	119	15.9	88	12.2	3.7
30-Closed Before Plan Initiated	34	4.5	33	4.5	0
Total	749	100%	722	100%	

VR Closure Statuses as of 6/19/75 for Experimental and Control Groups

	E Group		C Group		
	Frequency	Percent	Frequency	Percent	% Difference
Closure Statuses					
08-Closed from Referral Status	402	43.5	417	45.8	2.3
26-Closed Employed	323	34.9	316	34.7	.2
28-Closed Unemployed after Plan Initiated	152	16.4	129	14.2	2.2
30-Closed Before Plan Initiated	48	5.2	49	5.3	.1
Total	925	100%	911	100%	

APPENDIX B

EXHIBITS

EXHIBIT A

ROUTING SHEET

Date_____

Client_____ Employment status_____
Counselor_____ Vocational objective(s)_____
Client needs bus tokens? YES - NO. Marked visual impairments? YES - NO.
Medical and work history attached. Additional remarks_____

Referrals made or under consideration:_____

INSTRUCTION TO DIAGNOSTIC UNIT STAFF	FINDINGS
PSYCHOLOGIST Intelligence_____ Interest_____ Personality_____ Perceptual_____ Academic Achievement_____ Total Battery_____ Misc._____ .Evaluate emotional stability_____ .Check for intellective deficiencies caused by neurological impairment_____ .Is vocational objective appropriate_____ .Suggest alternative objectives_____ .Other_____	WAIS IQ's: V_____ P_____ FS_____ OT IQ_____ RPM IQ_____ BETA IQ_____ OTIS IQ_____ WRAT: Reading_____ Spelling_____ Arithmetic_____ Other test results and observations: _____ _____ _____
SOCIAL WORKER Family Background_____ Drug Abuse_____ Present Living Situation_____ Alcoholism_____ Psychiatric_____ Work_____ Education_____ Legal Problems_____ Interest_____ Home visit_____ Comments:_____ _____ _____ _____ _____ _____	
WORK EVALUATOR Dexterity: Fine_____ Gross_____ Work Factors_____ Clerical_____ Assembly_____ Personal Services_____ Professional & Managerial_____ Aptitude (specify)_____ .Is chosen vocational objective appropriate? _____ .Suggest alternative vocational objective. _____ _____	

EXHIBIT B

SOCIAL BACKGROUND INFORMATION

Office Interview_____ Date_____
Home Visit _____

INDIVIDUAL DATA

Name_____ Age_____
Available transportation_____
Place of orgin_____ Time in Houston_____
Unusual interests_____

FAMILY BACKGROUND

Person(s) responsible for upbringing_____
If other than parents, reason_____
_____
Client's assessment of childhood experience_____
_____
Economic situation in childhood_____
Client's relationship with parents during childhood_____
Client's relationship with parents at present_____
Siblings: No. brothers_____ No. sisters_____ Client's birth order_____
Client's relationship with siblings during childhood_____
Client's relationship with siblings at present_____
Relationship of the family as a whole_____
Age when left home_____ Reason_____
Comments_____
_____

PRESENT LIVING SITUATION

Living Situation: Self_____ Spouse _____ Children_____ Parents_____ In-Laws____
Friends_____ Others_____
Satisfaction of present living arrangements_____
Marital Status_____ No. Marriages_____ No. Spouses_____
Comments_____
_____
Cause of marital status_____
No. of dependents_____ No. of children_____ Ages_____
Name of spouse_____Age_____ Occupation_____

EDUCATION

Client's highest grade completed_____ If school drop out, why_____
Did client ever get into trouble with school? _____
If so give reason_____
Grade trouble started_____
Client's attitude toward teacher and principal in school_____
Client's favorite subject(s) in school_____
School subject(s) most disliked_____
Extra curricular activities while in school_____
Peer relationships_____
Special education_____ Starting grade in special education_____
College hours completed_____ Major_____ Minor_____
Degree_____ College attended_____
Languages: English: Understand_____, Speak_____, Read_____, Write_____
Spanish: Understand_____, Speak_____, Read_____, Write_____
Other: _____ Understand_____, Speak_____, Read_____, Write_____

TRAINING

Has client ever received occupational training_____ Completed_____
Places(s)_____ Subject(s)_____ Year_____
_____ _____ _____
_____ _____ _____

If training has been completed, what is preventing client from pursuing this trade?_____

WORK EXPERIENCE

Types of jobs done in past_____
Presently employed_____ If not, length of time since last stable employment____
Has client been actively looking for a job_____ How?_____
_____
Has he/she had any interviews_____ How many within last two weeks_____
Difficult with interviews_____Longest time in one job_____
Has client ever been terminated from a job_____Circumstances_____
_____ If reason for termination of last employment was a disability, what specific factors of the disability do not allow him to return to same job?
_____
Are there any similar jobs that he could do now and/or would like to do now?
_____
Job most liked_____
Client's description of optimal work situation:
Type of supervisor_____
Degree of work pressure_____
Company vs. isolation_____
Well defined vs. some autonomy_____
Hours_____
Work with people or things_____
Salary expected_____
Willingness to relocate_____
Others_____

VOCATIONAL INTEREST

Interested in school_____ Subject(s)_____
Job placement_____ Field_____
Reason for choosing specified subject_____
Does client know anyone working in chosen field_____ Whom?_____
Does he know anyone who can help him find employment in chosen field_____
Who _____ Relationship_____ Employer_____
Other interest_____
Hobbies_____

MILITARY SERVICE

Ever served in the military_____ Branch_____ Current Status_____
Age at enlistment_____ Specific occupation_____ Highest rank attained_____
_____ Overseas?_____ Where_____ Type of discharge_____
Date_____ Ever received psychiatric treatment while in service_____
If yes, presenting problem_____ Peer problem_____
Authority problems_____ Client's evaluation of military experience
_____

HISTORY OF ALCOHOLISM

Does client feel he/she has a drinking problem_____ Age drinking became a problem_____ Ever involved with AA_____ When_____
Frequency and amount of intake_____
What precipitated the drinking problem_____
Does client have any relatives with a drinking problem?_____ Who_____

DRUG ABUSE

Drugs ever used_____
Drugs currently using_____
For how long_____ How much used_____
How administered_____ Age drugs first used_____
How introduced_____
Favorite drug_____ Marijuana_____ Frequency and Quantity_____
Psychedelics_____ Hallucinations_____ Describe_____
Treatment received_____ Where_____
Date_____ Any "bad trips"_____ Any residual effect of drug use_____
Benefit derived from drug use_____

PREVIOUS PSYCHIATRIC HISTORY

Has client ever been involved in any form of therapy_____ Reason_____
_____ Name of therapist_____
Year(s)_____Length of treatment_____ Place(s)_____
Has client ever been hospitalized for psychiatric condition_____
Hospital(s) and year(s)_____
Length of hospitalization_____Shock Treatments_____
Has client ever taken any psychological testing_____ If so, which ones_____
_____ Where_____

PENAL HISTORY

No. of imprisonments_____Offenses leading to incarcerations_____
Total time incarcerated_____ No. of jail terms_____
Charges_____ Ever convicted_____Were you guilty_____
Charges dropped_____ Acquitted_____Presently on parole or probation_____ Parole/probation officer_____ Telephone_____
If on probation, what was offense?_____
Age at first trouble with law_____ Was there any educational training in prison _____ Specify_____

CLIENT'S DESCRIPTION OF SELF:_____
_____
_____

OBSERVATIONS:

EXHIBIT C

DIAGNOSTIC UNIT SOCIAL EVALUATION REPORT

NAME_____ AGE_____

DATE_____

FAMILY BACKGROUND

Place of origin_____
Person(s) responsible for upbringing_____
If other than parents, reason_____
_____
Client's assessment of childhood experiences_____
_____
Economic situation in childhood_____
Client's relationship with parents during childhood_____
Client's relationship with parents at present_____
Siblings: No. brothers_____ No. sisters_____ Client's birth order_____
Client's relationship with siblings during childhood_____
Client's relationship with siblings at present_____
Relationship of the family as a whole_____

PRESENT LIVING SITUATION

Present living arrangement: Satisfactory_____ Unsatisfactory_____
Comments_____
_____
Marital Status_____ No. Marriages_____ No. Spouses_____
Comments_____
No. of children_____ Ages_____ Illegitimate Pregnancy_____

TRAINING

Has client ever received occupational training_____ Completed_____
Place(s)_____ Subject(s)_____ Year(s)_____
_____ _____ _____
If training has been completed, what is preventing client from pursuing this trade?
_____

VOCATIONAL INTEREST

Training_____ What area_____
Job Placement_____ What area_____
Reason for choosing specified subject_____
Prefer: Indoor work_____ Outdoor work_____
Available transportation_____
Interests_____
Hobbies_____

MILITARY SERVICE

Ever served in the military_____ Branch_____ Current Status_____
No. of years_____ Dates_____ Specific occupation_____
Relationship with authority figures_____
Type of Discharge_____
Evaluation of military experience_____

HISTORY OF ALCOHOLISM

Does client feel he/she has a drinking problem_____ Age drinking became a problem_____ Ever involved in AA_____ When_____
Frequency and amount of intake_____
What precipitated the drinking problem_____
Length of time since client last used alcohol_____
Periods of sobriety_____ Blackouts_____ DT's_____
Hospitalizations_____

DRUG ABUSE

Drug use_____ Drugs used_____
Drugs now using_____ How long_____ How much_____
Treatment received_____ Where_____
Any residual effects of drug use_____
Client's assessment of drug experience_____
_____

PREVIOUS PSYCHIATRIC HISTORY

Has client ever been involved in any form of therapy_____ Reason_____
_____ Name of therapist_____
Year(s)_____ Length of treatment_____ Place(s)_____
Has client ever been hospitalized for psychiatric condition_____
Hospital(s) and year(s)_____
Length of hospitalization_____ Shock treatment_____
Attempted suicide_____

PENAL HISTORY

Total number of arrests_____ For what_____
Any serious arrests_____ Total number of convictions_____
Total time incarcerated_____ No. of jail terms_____
Presently on parole/probation_____ Parole/probation officer_____
Telephone_____

OTHER

1._____Chronic employment instability
2._____Dependence on Welfare
3._____Prostitution
4._____Sexual deviation
5._____Unsatisfactory peer relationship

CLIENT'S DESCRIPTION OF SELF_____
_____
_____
_____

OBSERVATION:

EXHIBIT D

Texas Rehabilitation Commission

COMMISSIONER FOR REHABILITATION Jess M. Irwin, Jr.

Room 100
5619 Fannin
Houston, Texas 77004

_____
Date

SPECIAL DIAGNOSTIC UNIT CLIENT

Dear Doctor_____:

_____is a client of our Special Diagnostic Unit which we previously discussed with you. Therefore, instead of your usual method of reporting by mail, please telephone your findings to our transcription unit at phone number_____.

Since this is an experimental-demonstration project, this particular service is available only for the clients involved in this project, and we are asking you to please call in only those cases designated as project cases by this type letter.

This transcription unit is located here in our Fannin Street office and can be dialed at all hours, seven days a week. After dialing the above number you will hear a split-second beep which indicates that you may begin your dictation. During dictation, any period of silence exceeding 12 seconds will result in a second beep and immediate disconnection. Should this occur, please re-dial the number and continue your dictation. The report will be typed promptly and returned to you for your perusal and signature.

Thank you for your cooperation.

_____
Counselor, Special Diagnostic Unit
Texas Rehabilitation Commission

EXHIBIT E

COUNSELOR QUESTIONNAIRE - COMMENTS

1. In terms of groups, think back over the clients that you received from the Diagnostic Unit versus those you received from other sources.

   (a) Which group was easier to work with?

   "I received almost all Diagnostic Unit cases which makes it hard to judge."

   (b) Which group, do you feel, showed the greatest motivation?

   "The paperwork was easier with Diagnostic Unit cases but I could not differentiate on motivation."

   "Initially the Diagnostic Unit cases."

2. (a) With Diagnostic Unit cases, did receiving so much information all at once cause any problems for you?

   "I prefer it all at once."

   "Extremely helpful as it was comprehensive as well as informative."

   "Never thought about 2 separate groups--all the same people."

   "The more information the better."

   "My Diagnostic Unit Star of Hope cases were all severe."

   "Occasional delays in receiving information causes case management problems."

   "I was frequently called before receiving the folder."

   "Excellent--Diagnostic Unit evaluated some of my very difficult cases."

   "The problem was getting too many clients at once."

   "Clients impatient for services--some personnel in Diagnostic Unit were not aware of time limitations of a counselor."

   "Some of the information seemed incomplete--typical in short-term testing situations."

Question 2 (a) continued:

"Diagnostic Unit cases gave me the type of material and information that I desired and would have taken more time to get, which causes delays."

"That's the ideal situation--to have all the information you can get at once."

2. (b) With Diagnostic Unit cases, did you feel so "well armed" by the comprehensive package of diagnostic information that you were tempted to accept (status 10) clients you normally would not have accepted?

"Felt I had to accept them due to all the effort."

"Concerning psychological especially."

(c) Did you tend to feel any obligation to accept (status 10) Diagnostic Unit clients because they were "special" in some way, i.e., might be scrutinized later?

"Except near the end when staff counselor met with counselor to receive cases."

"These cases were easier to make the acceptance or accept status 10 as a result of my being able to discuss cases with the Diagnostic Unit personnel."

"There was always a diagnosable disability; sometimes not the case using community diagnosticians."

(d) In your mind, did you tend to equate Diagnostic Unit cases with transfer cases coming to you from other counselors?

"Only a loose association though."

7. Call to mind the work evaluation reports (as a group) you received from the Diagnostic Unit. Rate them on the following points by placing an ✓ in the appropriate box.

"The vocational evaluations, while good, seemed to be of limited use across the board spectrum of work available in this area. Too much emphasis on manual skills and not enough on social aspects.

COUNSELOR QUESTIONNAIRE--GENERAL REMARKS

1. "Project concept was good."

2. "The Diagnostic Unit was extremely helpful to me. I am sorry the project is over."

3. "Anytime diagnostic services can be expedited so as to serve the client sooner and when he is ready is most important. We really need a Diagnostic Unit as it proved to be motivational to clients and generally aided in the "26"."

4. "I feel that the concept of accelerating intake is helpful for the emotional or non-physical disabilities. The Expedite project had an inherent value, i.e., reduction of waiting time for TRC services. I feel that such a program has value, regardless of any emphasis on production."

5. "In my opinion as a VR counselor the Diagnostic Unit served a very useful purpose for those counselors and their clients to speed up the rehabilitation process as a whole. The information received from the Diagnostic Unit was always very helpful in giving me what I needed to adequately serve my clients. Upon receiving the cases from the Diagnostic Unit I was assured that the client knew what to expect from the agency as well as what the agency expected of him including vital materials. I spent a great deal of time in the Diagnostic Unit discussing case information and was helped by what I received. I feel that it would be of great service to have the Diagnostic Unit as a functioning part of the system, in such a way that every unit could be served."

6. "Work Evaluation was good but seemed limited in scope. Other areas of information might be emphasized i.e., assertiveness, need for structure or non-structure, independence vs dependence, manager orientation, leader/follower, extrinsic-intrinsic, authority conflict, extrovert-introvert, conformity-non-conformity, frustration level, endurance, achievement needs, adventure needs, competitiveness, need for security, etc."

7. "Psychological evaluations usually were shy in the area of how a client handled his anxiety and how to assist the client along these lines vocationally. Could have used more vocational suggestions and social evaluation and/or prediction. They were excellent in terms of establishment

of disability, however.

Work evaluations were thorough and well done but of limited scope. Little information was seemingly useful. Possibly they were too elementary and basic.

Social histories were usually quite good and useful in gaining behavioral information.

Generally I feel the format of the Diagnostic Unit was very good, expeditious, and assisted the counselor well. I hope the system is adopted for regular use."