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ABSTRACT

This paper addresses problems encountered by minorities in accessing the state/federal vocational rehabilitation (VR) system, how minorities have fared in the system, the lack of trained minorities in the VR counseling profession, and a comparison of private-for-profit and state/federal VR programs. Minorities considered include Blacks, Hispanic Americans, Asian Americans, and Native Americans. The paper concludes that minorities with disabilities are less likely than Whites with disabilities to be found eligible for state/federal services, are less likely to be rehabilitated, and are provided fewer opportunities for academic training. Eleven research, training, and policy recommendations are offered. A reaction to the paper by Madan M. Kundu cites studies showing that race is a predominant factor in rehabilitation outcome and offers recommendations for state/federal VR systems, rehabilitation counselor training programs, the Rehabilitation Services Administration, and the National Institute on Disability and Rehabilitation Research. The reaction paper contains a list of 19 references and 9 reference materials. A second reaction, by Eddie E. Glenn, calls for the Rehabilitation Services Administration to reexamine its traditional approach to increasing the awareness of, understanding of, acceptance of, utilization of, and commitment to VR services. (Contains 31 references.) (JDD)

The Vocational Rehabilitation of Minorities

Frank L. Giles

[and]

Reaction to The Vocational Rehabilitation of Minorities

Madan M. Kundu

Reaction to The Vocational Rehabilitation of Minorities

Eddie E. Glenn

The Vocational Rehabilitation of Minorities

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It is estimated that over 43 million Americans have some type of disability. Of this total in 1988, some 13,420,000 working-age adults between the ages 16-64 had a disability and 7,457,000 or 55.6% of these persons were considered to be severely disabled (Bowe, 1992). As of 1988, Blacks and Hispanics represented one in three of working-age adults with a severe disability, compared to just over one in five in 1982. While the proportion of Whites with work disabilities fell from 8.4% in 1982 to 7.9% in 1988, during the same period the proportion of disabilities among Blacks rose from 13.4% to 13.7% and for Hispanics 8.0% to 8.2%, respectively (Bowe, 1990, 1992). According to the Bureau of the Census (U.S. Department of Commerce, 1989), approximately 3,523,000 Blacks and Hispanic Americans have a working-age disability (this figure excludes individuals in institutions). If one combines this total with individuals who are Asian-American and Pacific Islanders, along with Native-Americans with disabilities, a sizable portion of people of color in the United States have disabilities.

This paper will focus on problems encountered by minorities in accessing the state/federal vocational rehabilitation system, how minorities have fared in the system, the lack of trained minorities in the profession of vocational rehabilitation (VR) counseling, and a brief comparison of private-for-profit VR and state/federal VR programs. General recommendations for each of the above topical areas will also be provided.

For the purpose of this paper, Black and African-American will be used as an interchangeable terms. The term Hispanic-American will be utilized to describe Americans of Mexican origin, Puerto Ricans, and Central and South Americans. The author will utilize ethnic terms recommended by the primary sources when referring to certain Hispanic ethnic groups in an effort to accurately depict the needs of this diverse population. Similar attempts will also be made when describing both Americans of Asian descent and Native-Americans.

African-Americans with Disabilities

The heritage of Americans of African origin continues to evolve with regard to their ethnic identity within American society. As depicted in the late Alex Haley's book Roots, African-Americans were the only racial group forcibly brought to America's shores, enslaved, sold as property, and counted as three-fifths of a person (Giles & Lustig, 1988). A significant portion of African-Americans still carry psychological scars caused by years of bigotry which in turn has led to an air of mistrust in the White majority. In a recent poll of readers of Ebony (1988), 66% of the respondents felt that Whites have "little" sympathy for the struggle of Blacks. Another 25% indicated that they felt that Whites have "no" sympathy at all. These findings suggested that it is likely that African-Americans may be somewhat skeptical or in some cases passively resistent to efforts to initiate services such as VR.

In a landmark study Atkins and Wright (1980) using data provided by the U.S. Department of Education, Rehabilitation Service Administration (RSA), they found that Blacks were more likely to be found ineligible for VR when compared to Whites. If found eligible, Blacks were less likely than Whites to be rehabilitated. They also found that Blacks, when compared to Whites at referral for VR, were more likely to be poor and on welfare. The educational level of Black applicants for VR was on a lower plane than for Whites. Blacks were less likely to be provided education or training. Less costly VR services were provided for Blacks.

Danek and Lawrence (1982), in a review of rehabilitation outcomes, found that more time was required for Blacks to be accepted for VR services when compared to Whites. In a recent analysis of data from the Pennsylvania Office of Vocational Rehabilitation conducted by Herbert and Martinez (in press), one in three (33%) Anglos (Whites) were found to be ineligible for VR services when compared to two in five (40%) persons of color. "By definition, ineligibility for services results when the counselor perceives that either the client's disability does not represent a substantial barrier to employment or that there is no reasonable expectation that with rehabilitation services, the client will achieve employment" (Herbert & Martinez, in press, p. 8).

RSA data indicated that Blacks represented 18.2% (see Table 1) of all rehabilitated cases in fiscal year (FY) 1984 (U.S. Department of Education, RSA 1989).

Table 1
Characteristics of Persons Rehabilitated by State Vocational Rehabilitation Agencies Fiscal Years 1986 and 1984

	1986		1984	
Items	Total	Percent	Total	Percent
New Applications (a)	594,000	---	594,000	---
Percent accepted (b)		58.0		59.0
All rehabilitations	223,354	---	225,772	---
Mean Age	32.6 years		32.5 years	
Sex Reporting (c)	214,058	100.0	218,915	100.0
Male	119,013	55.4	123,821	56.6
Female	95,045	44.6	95,094	43.4
Race Reporting (c)	213,854	100.0	218,245	100.0
White	170,768	79.9	174,379	79.9
Black	39,088	18.3	39,813	18.2
American Indian/ Alaskan Native	1,109	0.5	1,240	0.6
Asian and Pacific Islander	2,889	1.4	2,813	1.3
Reporting Yes or no Hispanic origin (c)	218,554	100.0	209,420	100.0
Persons of Hispanic Origin	15,659	7.2	13,464	6.4
Persons not of Hispanic Origin	202,895	92.8	195,956	93.6

a=Applicants processed for program eligibility
b=Percentage of applicants accepted for services
c=Number of individuals reporting requested information

For FY 1986, Blacks represented 18.3% of all rehabilitated cases, however in FY 1988 and FY 1989 (see Table 2) the numbers declined to 17.7% and 17.4, respectively (U.S. Department of Education, RSA, 1990). By comparison,

Table 2
Characteristics of Persons Rehabilitated by State Vocational Rehabilitation Agencies Fiscal Years 1989 and 1988

	1989		1988	
Items	Total	Percent	Total	Percent
New Applications (a)	624,000	—	606,000	—
Percent accepted (b)		58.0		58.0
All rehabilitations	220,408	—	218,241	—
Mean Age	33.8 years		33.3 years	
Sex Reporting (c)	219,953	100.0	218,357	100.0
Male	123,017	55.9	122,517	56.1
Female	96,936	44.1	95,840	43.9
Race Reporting (c)	219,518	100.0	217,785	100.0
White	177,244	80.7	175,150	80.4
Black	38,156	17.4	38,573	17.7
American Indian/ Alaskan Native	1,286	0.6	1,210	0.6
Asian and Pacific Islander	2,832	1.3	2,852	1.3
Reporting yes or no Hispanic origin (c)	214,240	100.0	217,945	100.0
Persons of Hispanic Origin	17,454	8.1	16,381	7.5
Persons not of Hispanic Origin	196,786	91.9	201,524	92.5

a=Applicants processed for program eligibility

b=Percentage of applicants accepted for services
c=Number of individuals reporting requested information

Whites in FY 1984 represented 79.9% of all cases rehabilitated representing an increase to 80.7% in FY 1989 over the same period. It should be noted that the proportion of Blacks with a working-age disability was 13.0% in 1984 followed by an increase to 13.7% in 1988. For the same period between 1984 to 1988, the number of Whites by proportion with a work disability fell from 8.1% to 7.9%, respectively.

Atkins (1988) advocated utilizing an asset-oriented strategy in providing VR services for African-Americans. She observed that rehabilitation philosophy is built upon a principle which predicates that an individual's strengths and abilities should be developed to facilitate growth. From her viewpoint, the strategy should reflect "a belief that positive outcomes originate from shaping strengths and failure results from a concentration on limitations, fears and negatives" (Atkins, 1988, p. 45).

In a unique study of rehabilitation outcomes and environmental support for Blacks with disabilities, Belgrave and Walker (1991) found that individuals who owned vehicles were twice as likely to be employed than those with no transportation. The researchers perceived employment as leading to being able to purchase a vehicle as opposed to vehicle ownership leading to employment as important. Social support was found to be the next strongest predictor of employment of Blacks with disabilities.

Hispanic-Americans with Disabilities

"Hispanic" is often used as a descriptor of people of Mexican descent, Puerto Ricans, Cubans and persons from Central and South America. Arredondo (1991) noted that people from Central and South America, often prefer to be identified with their national origin, such as Dominican or Columbian. Fierro and Leal (1988) suggest that Americans of Mexican origin prefer to be described or addressed as "Chicano". Arredondo (1991) and Fierro and Leal (1988) noted that "Latino" may be a more responsive term and is sometimes preferred to "Hispanic".

Socialization and acculturation by Latinos is often impeded by bilingual ability, color, migration and/or immigration, legal or illegal status, and membership in a specific subgroup (Arredondo, 1991). RSA currently employs a client classification system which accounts for perceived differences in racial and ethnic identity among Hispanics (U.S. Department of Education, RSA, 1990). By definition, racial identity denotes a human biological characteristic, whereas ethnic identity relates to an individual's perceived cultural heritage. At face value, such classification strategies are usually benign and provide a means to accurately document Hispanic consumers of VR services. However, the danger of such systems is the same information can be employed to "screen-in" or "screen-out" certain consumers.

There is very little empirical research about the participation of Hispanics in

the state/federal VR system. Rivera (1974) found that Hispanics, when compared to Whites, were more likely to be found ineligible for VR services. He also reported that Hispanics, when compared to Whites, remained in referral and applicant statuses for a longer duration, were less likely rehabilitated, supplied less academic training and received less money for VR services. Herbert and Martinez (in press) also found that Hispanics were more likely to be found ineligible for VR services and less likely to be successfully rehabilitated when compared to Whites.

RSA data indicates that individuals of Hispanic origin in fiscal year (FY) 1984 (see Table 1) represented 6.4% of all cases rehabilitated. By FY 1989 (see Table 2), the number of Hispanics rehabilitated increased to 8.1% of all cases rehabilitated.

Rivera and Cespedes (1983) advocated reaching out to Hispanic persons with disabilities by visiting them in their cultural and personal environment. They further recommended visiting Hispanic churches, community organizations, and meeting with community leaders as a means to increase Hispanic persons involvement in VR services.

Asian-Americans with Disabilities

Asian-Americans are far from the homogeneous group they seem to be. Within the category of Asian-American and Pacific-Islanders there exists at least 32 distinct ethnic or cultural groups (Wong cited in Leung & Sakata, 1988).

The shear magnitude of the various ethnic and cultural groupings indeed suggests that rehabilitation professionals should utilize caution when exercising broad generalizations about Asian-Americans with disabilities. Census data from 1980 indicates that there are approximately 3,726,000 Asian and Pacific Islanders in the U.S. Approximately 74% of the population has completed four years of high school or more. The largest ethnic group represented are the Chinese-Americans with an estimated population of 812,000.

Asian-Americans have been subjected to the "model minority" label. This notion fosters a perception that Asian-Americans have somehow "over-come" their minority status and succeeded in all facets of American life. This designation further suggests that Asian-Americans should thus be denied or have limited access to public support available to other minority groups.

RSA data indicated that in FY 1989 (see Table 2) the public VR program rehabilitated 2,832 Asian and Pacific Islanders. Similar numbers of individuals were rehabilitated in fiscal years 1984, 1986 (see Table 1) and 1988.

Whether to seek VR services may depend upon the length of time a person has been present in the U. S. For example, immigrants and refugees may not be familiar with the language or customs of the U.S. Leung and Sakata (1988) noted some immigrants have an advantage over refugees by preparing for relocation and learning skills which may be needed for successful adjustment. On the other hand, refugees

may have no choice but to seek security in a new country secondary to political pressures in their country of origin. Other factors which may create barriers to the VR of Asian-Americans include acquisition of the language of the dominate culture, traditions and customs (e.g., filial piety), perceptions of the sick role, and family support (Leung & Sakata, 1988).

Native-American with Disabilities

There are 309 Native-American tribes and 197 tribal villages in Alaska recognized by the U.S. Government (Federal Register, cited in Martin, Frank, Minkler, & Johnson, 1988). Martin et al. reported that RSA has funded 13 tribal-operated VR projects as of July 1988. In 1975, the Navajo Tribe became the first Native-American Tribe to operate a VR program which was funded through a grant from the Arizona Rehabilitation Services Administration (Guy, 1988). In 1983, it was estimated that nearly 180,000 Navajo people lived on the Navajo reservation which is located in the states of New Mexico, Arizona and Utah (Lowery, 1983). From 1981 to 1988, approximately 400 individuals with disabilities were placed into employment as a result of the Navajo program.

RSA national data indicated that in FY 1984, 1,240 Native-Americans and Native Alaskans were rehabilitated (see Table 1). Overall, rehabilitated cases have continued to be rather stable for fiscal years 1986, 1988 and 1989 (see Table 2).

Several factors have been found to present barriers to the VR of Native-Americans who live on reservations. These factors include: (a) cultural differences, (b) transportation problems to obtain VR services, (c) few employment opportunities on or near reservations, (d) a lack of self-initiative and commitment to VR long-term goals, (e) language problems, and (f) substance abuse problems. Problems associated with Native-Americans living in urban areas were limited family and cultural support, no recognized central agency with whom to communicate social service needs and a greater financial burden associated with living in a city (White cited in Martin, et al., 1988). Similar findings were reported in a study of 332 VR counselors in 25 states and two VR programs operated by tribes. Martin et al., (1988) found that 50% of the clients-on-reservation counselors felt that it was okay for their clients to accept native healing approaches to disabilities. Only 31% of the clients-off-reservation counselors approved of such practices. Both clients-on-reservation counselors and clients-off-reservation counselors overwhelmingly reported the importance of the remediation of deficits in English proficiency among clients. Over 90% of both counselor groups reported that it was important to receive test results which were culturally relevant.

Finally, the study indicated that client-on-reservation counselors reported that "Indian Attitudes Toward Health and Disabling Conditions" ranked first and "Interviewing and Counseling Skills with Indian Clients" ranked second with regard to VR counselor training needs. Clients-off-reservation counselors indicated that "Services Available to Indians Living Off Reservations" ranked first and "Vocational Evaluation Approaches" ranked second with regard to training needs.

Training of Minorities in Rehabilitation Counseling

The National Council on Rehabilitation Education (NCRE) represents rehabilitation educators, trainers, researchers, doctoral students, and others primarily concerned with the preparation and maintenance of professional standards for individuals who deliver services to persons with disabilities. The NCRE 1991-92 Membership Directory (1992b) lists 72 institutional members composed of colleges and universities in the U.S. and Puerto Rico. To determine the number of historically and predominantly Black colleges and universities with programs in rehabilitation education, the author compared the NCRE institutional membership list against a list 117 recognized predominantly and historically Black colleges and universities (HBCU) (National Association for Equal Opportunity in Higher Education, 1992). There were four rehabilitation education programs which are institutional members of NCRE and located within HBCU. These institutions include Jackson State University (Jackson, MS), Southern University (Baton Rouge, LA), South Carolina State University (Orangeburg, SC) and the University of Maryland - Eastern Shore (Princess Anne, MD). The University of Maryland - Eastern Shore program began in 1988 and offers a bachelor's degree in rehabilitation services. The other three programs offer master's level training in rehabilitation counseling. (The author is personally aware of two additional rehabilitation programs located in historically black colleges.) Fort Valley State College (Fort Valley, Georgia) has a master's level rehabilitation counseling program and Talladega College (Talladega, Alabama) has a bachelor's level rehabilitation services program.

By reviewing the program descriptions of all rehabilitation programs listed in the current NCRE Directory (1992b), only two programs identify themselves as having a significant enrollment of Hispanic students. These programs include the University of Puerto Rico which offers a master's degree in rehabilitation counseling and the University of Texas - Pan American (Edinburg, Texas) which offers a bachelor's degree in rehabilitation services. The University of Hawaii (Honolulu, HA) offers a master's degree in rehabilitation counseling and has a significant enrollment of Asian-Americans.

NCRE data pertaining to master's level rehabilitation counseling programs indicates that between 1989 to 1991 non-white students enrolled in master's level rehabilitation counseling programs represented only 15.8% (see Table 3) of all rehabilitation counseling students from reporting institutions (NCRE, 1992a). Roughly, the average number of non-white students enrolled in master's level rehabilitation counseling for the years between 1982 through 1991 (no data was collected in the 1986-87 academic year) was approximately 17.8%.

Table 3
National Council on Rehabilitation Education Master's Level Rehabilitation Counseling Programs Student Enrollment Data

Years	82-84	84-86	87-88	89-91
Surveys Returned	60	56	61	58
Number of Graduates Average per program (two year period)	11.8	13.5	11.8	13.6
Demographics Percentage (%)				
Non-White	16.6	15.6	23.5	15.8
White	83.4	84.4	76.5	84.2
Females	72.8	74.8	78.1	71.8
RSA Trainee	48.4	50.7	58.3	53.3
Individual with Disabilities	15.7	15.2	20.7	21.6

Note: Data for the Fact Sheet for 1986-87 was not collected.

The U. S. Department of Education, RSA provides grant support to several academic programs in higher education to meet the employment needs of state/federal agencies responsible for providing VR services. NCRE data indicated that between 1982 to 1991 (no data was collected in the 1986-87 academic year), RSA stipends were extended to approximately 52.6% of all students enrolled in master's level rehabilitation counseling programs.

According to the National Training Needs Analysis and Summary of 1990, (RSA, 1991) regional reports have recommended continued funding for universities which recruit "students that are bi-lingual, or represent minority populations" (p. 15). Available information regarding RSA grant support to rehabilitation education programs in minority institutions indicates that Jackson State University (1992 last year of three year grant), South Carolina State University (personal communication Eddie Glenn, April 6, 1992) and the University of Texas - Pan American (through 1994) (NCRE, 1992b) are currently funded.

Clearly, the need to continue to provide RSA support through grants to institutions of higher education with significant enrollment of minority students is critical to maintaining and increasing the numbers of minority persons represented in the rehabilitation profession.

Private-for-profit Vocational Rehabilitation

With its beginning in the 1970's in California, private-for-profit rehabilitation

firms have experienced a burgeoning growth in providing VR services to individuals typically with industrially related injuries. Referral sources for private sector firms include insurance companies, attorneys, state workers' compensation bureaus, private industry, employee assistance programs and various other sources. Matkin (1983) observed in a study of members of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) that 94.6% of respondents reported providing services in the area of vocational counseling and 70.1% in job restructuring consultation. He noted that these services did not appear to reflect the traditional role and function of rehabilitation counselors in state/federal VR agencies. Commonly offered services in the private sector such as medical case management, vocational testimony, labor market surveys, and job analysis have generally received less emphasis in the public sector.

By comparison, rehabilitation counselors in the private sector usually carry a caseload between 25 to 30 clients, whereas in the public sector it is common for caseloads to exceed well over 100 clients. Hence, it is difficult to compare the private sector and state/federal rehabilitation delivery systems with regard to the effectiveness of services provided to minorities with disabilities.

Summary

In general, minorities with disabilities are less likely accepted or found eligible for state/federal (VR) services when compared to Whites with disabilities. If accepted for VR services, minorities are less likely rehabilitated and provided fewer opportunities for academic training when compared to Whites. RSA data regarding individuals rehabilitated between FY 1984 to FY 1989 indicated that the number of American Indians/Alaskan Natives, and Asian-Americans and Pacific Islanders rehabilitated cases have remained fairly stable during the period. The number of Hispanic-Americans rehabilitated increased slightly during the same timeframe. Even though the number of African-Americans with a work disability increased between 1984 to 1989, the number of African-Americans rehabilitated by RSA decreased.

Both the American Association of Counseling and Development (AACD) and the American Psychological Association (APA) (both organizations have a division devoted to rehabilitation) have recognized the significance of service delivery systems which appropriately meet the needs of the culturally diverse American population. In 1973, the Vail Conference of APA recommended to providers of psychological services that it is unethical for individuals who are not competent in understanding the needs of persons from culturally diverse populations to supply services to such populations.

Rehabilitation counseling pre-service academic training programs may also have a critical impact upon the success or failure of minorities with disabilities in the state/federal VR system. Herbert and Cheatham (1988) observed that for the most part rehabilitation counselors are trained within the confines of a Eurocentric Counseling Model. The Eurocentric model connotes "a belief in the comparative

superiority of Anglo-American culture, in particular and in Euro-American culture, in general" (Jackson cited in Herbert and Cheatham, 1988, p. 51). "As such, it emphasizes Western European values, ethos, and beliefs, valuing mastery over nature, competition, individuation and theoretically, at least, it emphasizes rigid adherence to time" (Herbert and Cheatham, 1988, p. 51). Consequently, the history, culture, needs and interest of people of color are likely devalued and not adequately recognized as critical variables in the delivery of rehabilitation services.

Recommendations

1. Conduct research to determine which counseling approaches are most effective in delivering VR services to the various minority groups.

2. Conduct research to determine which VR counselors are most effective in delivering VR services to the various minorities groups (e.g., VR counselors with Master's degree in rehabilitation counseling, counselors with training in serving minorities, or more experienced VR counselors).

3. Fund research and training centers which devote their resources toward studying the needs of specific minority populations with disabilities.

4. Determine the training needs of state/federal VR agencies with regard to the delivery of services to minorities with disabilities.

5. Encourage rehabilitation counselor training programs to include specific courses pertaining to multicultural counseling and recommend the exposure of students to clinical training experiences involving minorities with disabilities.

6. RSA should continue to encourage the recruitment and training of underrepresented minority rehabilitation professionals in institutions of higher learning.

7. RSA should continue to fund colleges and universities with substantial enrollments of minorities in rehabilitation counselor training programs.

8. RSA should fund and encourage the participation of minorities in doctoral level rehabilitation counseling programs to increase the number of minority rehabilitation educators.

9. RSA should evaluate their policies pertaining to the delivery of services to minorities with rehabilitation.

10. RSA should evaluate the role of minorities professionals within state/federal VR programs to determine their role in establishing agency initiatives which impact upon minorities with disabilities.

11. RSA should increase the number of tribal operated VR programs to

increase the effectiveness of services provided to Native-Americans and Alaskan Natives.

Minorities with disabilities are in a situation of "double jeopardy" due to being a person from a minority group, coupled with the fact that many able-bodied persons (i.e., nondisabled persons) often perceive individuals with disabilities in a negative fashion. Rehabilitation as a profession should reach out to minorities with disabilities to aid their broader participation in American society. With the sincere efforts of all responsible parties, rehabilitation services available to people of color can be significantly improved.

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Reaction to The Vocational Rehabilitation of Minorities

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Dr. Giles, in his presentation, alerts us to issues of vocational rehabilitation (VR) services for minorities with disabilities. He focused on three major areas:

1. Problems encountered in accessing state-federal VR system by minorities with disabilities.

2. Lack of trained VR counselors who are minorities.

3. Comparison of state-federal VR system vs. private-for-profit rehabilitation programs.

Pertaining to the first issue, the author gave an excellent overview, with supporting data, which depicts the current status of minorities with disabilities in the United States. The state-federal VR system has made great strides in rehabilitating persons with disabilities since the inception of the program in 1920. However, the question of effectiveness in rehabilitating minorities with disabilities still persists. Dr. Giles diligently compared data on eligibility, ineligibility, number of services provided, time spent, and number of cases closed as rehabilitated.

With regard to the second issue, he depicted a dismal picture of educating qualified minority rehabilitation counselors in 110 NCRE and CORE accredited institutions and 117 historically Black colleges.

The third issue, public vs. private-for-profit rehabilitation services, is difficult to compare in the absence of available data based on empirical investigations. Private-for-profit rehabilitation represents the other side of the coin or a different facet of rehabilitation services. Consumers of private-for-profit rehabilitation are already employed and due to injury or illness in employment, they are referred by their employers, employee assistance programs, attorneys, insurance companies, and workers' compensation agencies. On the other hand, the majority of ethnic minorities with disabilities have individual and social barriers in accessing the public rehabilitation system. However, comparisons can be made on the following

dimensions: mode of delivery, types and quality of services, and outcome.

Response may be made on any dimension of the multifaceted issues raised by Dr. Giles. However, a few major issues will be discussed and pertinent recommendations will be made. The major thrust is that minorities with disabilities have an increased rate of ineligibility for VR services, eligibility determination takes longer, eligible individuals receive fewer services, rehabilitation process is long, and fewer cases are closed successfully.

The outcome of any social, behavioral, or rehabilitation intervention is a function of its participants and the internal and external social situation in which it operates (Fairweather & Tornzatzky, 1977). The rehabilitation outcome, in this instance, in the state-federal VR System should be viewed as a function of the participants, the rehabilitation clients who are minorities with disabilities.

The internal social situations in which these individuals are born, reared, quality of stimulation received, educated, and the environment they live in have a significant impact on the rehabilitation outcome. The external social situations in which minorities with disabilities are perceived, receive services, and those who provide services also have a significant impact on the rehabilitation outcome. The characteristics of the providers such as counselors, process variables, agency resources, mode of service delivery, and the philosophy of the agency have tremendous impact in the rehabilitation outcome. For example, counselor characteristics such as sex, race, education, perception and sensitivity to the needs of this special population, values, ethics, philosophy of service, and resourcefulness make a significant difference in rehabilitation outcomes.

This conglomerate of variables or factors interact in a multifaceted and complex way which ultimately determines the quality of rehabilitation outcomes. If we are indeed sincerely concerned with the plight of minorities with disabilities, then all the internal and external factors need to be addressed at the grassroots level using an holistic approach.

Kunce and Miller (1972) used a sample of 6,099 clients and cross validated on 3,995 clients who were closed cases by two Mid-Western state agencies. Race was one of the factors in the rehabilitation outcome. Atkins and Wright (1980) found significant statistical differences comparing Blacks and Whites on a number of dimensions throughout the rehabilitation process. Worral and Vandergoot (1980) used 6,263 closed cases of Oregon Vocational Rehabilitation clients during 1978. They have replicated the same study on 6,224 subjects in the same agency for cross validation purposes (Worral & Vandergoot, 1982). In both cases, among others, race was a predominant factor in rehabilitation outcome.

In an empirical investigation on active caseloads of clients and a six-month follow-up on post VR services in Louisiana, Michigan, and New York, Kundu (1983) found that on demographic characteristics, race was one of the major contributing factors to outcome. Stepwise discriminant analysis was significant in predicting VR

outcome, employed and unemployed, on four variables: race (Whites and non-Whites), number of dependents, secondary disability, and sources of support at referral.

Baldwin and Smith (1984) investigated the role of race and the impact socio-demographic variables have on the referral and rehabilitation process. Multiple regression analysis concluded that race had either a direct or indirect effect on the outcome. Findings of Kunce and Miller (1972), Atkins & Wright (1980), Worral and Vandergoot (1980, 1982), Kundu (1983), and Baldwin & Smith (1984) further validate the status of minorities with disabilities in the current VR system.

As the status of ethnic minorities with disabilities was established above and by Dr. Giles, let us focus our attention on the future. What are the prospects and challenges for these individuals as we rapidly approach the 21st Century?

Labor force projection for the year 2,000 (U.S. Department of Labor, 1987) indicate that:

* The proportion of Blacks, Asians, and others in the labor force will increase.

* Blacks will grow faster than Whites because of high birth rates.

* Asians and others will grow faster than Whites because of immigration and higher birth rates.

* The Hispanic labor force will rise from eight million to fourteen million in the year 2000. Growth will occur because of immigration and the rise in the native-born Hispanic population.

* The Hispanic share of the labor force will increase from seven percent in 1986 to 10% in 2,000. (p.11-12)

In 1989, the number of non-institutionalized Black and Hispanic of working-age disability was reported to be 3,523,000 Americans (U.S. Department of Commerce, 1989). If other ethnic minorities with disabilities such as Native Americans; Pacific Islanders, Americans of Asian, Chines, Cuban, Japanese, Korean, Puerto Rican, Vietnamese, and Arab descents are added, then the increasing trend in working-age disability among minorities in the year 2,000 would represent a significant percentage of the total labor force.

Is the state-federal VR system ready to accept these challenges of preparing a segment of the society who are economically disadvantaged, under educated, have limited training or skills, lack transportation, need increasing assistance in language, encounter attitudinal barriers, need job seeking and retention skills; while the jobs in the year 2000 will demand higher skill levels than ever before? The answer will be a mixed one. The State-federal VR system as well as other social institutions that serve these populations, needs an overhaul with innovative changes.

The traditional approach of educating, training, and employment assistance for ethnic minorities with disabilities has yielded limited success. Both individual attitudes and social institutions such as the VR system and other human services organizations must change (Hudson Institute, 1987).

Recommendations for State-Federal VR System:

1. Outreach: VR needs to develop and embark upon non-traditional outreach programs by developing linkages with community centers, churches, clubs, and social organizations where ethnic minorities participate actively and maintain their identity. For example, Black churches, Hispanic churches, Asian temples, and Indian Reservations are major sources to develop linkage. Church plays a vital role as community service organization and has a major influence on members providing emotional and motivational support. Churches, religious contacts (Hopkins, 1991), and inner-city community organizations can develop a network of information dissemination and on-going support activity in accessing VR services.

SPEED Model to Access, developed by Howard University Rehabilitation Project, is one such innovative approach. The model was replicated as Project Helping Hands, a client support model linking community and service agencies to outreach target populations (Wells & Banner, 1986). Similarly, Community-based Support Systems (King, 1986), Action-based Programming, and Information Center for Handicapped Individuals (ICHI) (Galiber, 1986) models need to be replicated across the nation.

2. Recruit qualified rehabilitation counselors, supervisors, state directors of various ethnic origins who possess extraordinary enthusiasm, expertise, and zeal in developing innovative outreach activities to serve as role models (Atkins, 1988). Representation of ethnic minorities in these decision and policy making positions are disproportional to the number of cross-cultural clients being served. For example, out of 82 state agencies (general and blind) in the country, only 5 states' directors are minorities. In Louisiana, out of 142 counselors, 22 are Black in addition to the state director. Similar data on counselors, supervisors, administrative staff, and other personnel were not available from RSA. These types of information would be of immense help in future interventions.

3. Develop in-service training modules to increase awareness, sensitivity, attitudinal shift/change on multi-cultural issues for counselors, supervisors, and administrators.

4. Develop and acquire resource materials such as books, journals, proceedings, other relevant literature, and make them available to agency personnel. A list of resource material is provided in the Appendix.

5. Initiate cultural awareness training for referral sources consisting of human services organizations such as SSDI, SSI, AFDC, FOOD STAMPS, etc. with a view to developing a sound network. Periodic education of the referral sources will

enhance accessing VR services by ethnic minorities with disabilities.

6. Encourage VR personnel to become members of special divisions such as National Association on Multicultural Rehabilitation Concerns of the National Rehabilitation Association, and Association for Multicultural Counseling and Development of the American Association for Counseling and Development.

7. Analyze service delivery patterns at statuses 02, 08, 26, 28, and 30 for ethnic minorities (Ross & Biggi, 1986) and develop strategies to eradicate current pitfalls and thereby increase rehabilitation rate. These analyses should be done at state, district, supervisory, and individual counselor levels.

8. Collaborate with local university rehabilitation counselor training programs in meeting educational needs on issues of multi-cultural counseling and local ethnic needs.

Recommendations for Rehabilitation Counselor Training Programs:

1. Outreach and promote recruitment of students and educators who are minorities and especially persons with disabilities who can serve as role models (Atkins, 1988).

2. Provide financial incentives such as graduate assistantships, scholarships, or fellowships in pursuit of their academic endeavors.

3. Infuse cultural diversity and ethnic-disability issues across curriculum with special emphasis on the following:

A. Current textbooks of counseling theory and technique focuses only on eurocentric counseling models. Two of the widely used texts, Current Psychotherapies (4th ed.) (Corsini & Wedding 1989) included a section on Asian Psychotherapies and Theory and Practice of Counseling and Psychotherapy (3rd ed.) discussed Ethical Issues in a Cross-Cultural Perspective in two pages (Corey, 1986). Ethnocentric counseling approaches are covered in such texts as Multicultural Issues in Counseling: New Approaches to Diversity (Lee & Richardson, 1991) and Counseling the Culturally Different (Sue & Sue, 1990) or other relevant materials need to be supplemented with current texts.

B. Casemanagement, Medical, Psychosocial Aspects of Disability, and Job Placement classes should incorporate exercises involving ethnic-disability case studies.

C. Standardized test instruments were basically developed for anglo-saxon populations. Ethno-centric or Afro-centric assessment instruments are limited or non-existent at this time. This is also true for persons with disabilities. The students in rehabilitation assessment and vocational evaluation classes must be made aware of the danger in the administration and interpretation of culturally biased tests for

persons who are culturally different.

D. Introduction to rehabilitation counseling class or field visits to community organizations would be of help in sensitizing students to ethnic-disability issues.

E. Practicum and internship activities are rich sources in gaining first-hand experience for students to learn about minorities with disabilities.

4. Develop leadership role by organizing workshops, seminars, and symposia on ethnic-disability issues involving students, faculty, professional counselors, personnel of human services organizations, and other community agencies with a view to provide community education.

5. Develop and acquire a list of resource material such as books, journals, proceedings on issues relevant to this special population, and make them available to students and faculty at the department or the university library. A list of resource material is provided in the Appendix. Ethnic minorities with disabilities: An annotated bibliography of rehabilitation literature (Wright & Emener, 1989) is an excellent and absorbing source which lists 526 references on Asian, African, Hispanic, and Native Americans with disabilities.

6. Encourage students and faculty to join the special division of NRA, National Association on Multicultural Rehabilitation Concerns, and AMCD, Association for Multicultural Counseling and Development.

7. Foster research on ethnic-disability related aspects by graduate students and faculty members which is an unexplored frontier.

Recommendations for RSA:

1. Out of 110 CORE accredited and NCRE member institutions and 117 historically Black colleges, only 9 minority institutions (Coppin State University, Fort Valley State College, Jackson State University, South Carolina State University, Southern University, University of Hawaii, University of Maryland-Eastern Shore, University of Puerto Rico, and University of Texas at Pan American) offer rehabilitation counselor training.

Historically, Black colleges and universities are often unable to generate matching funds. RSA must encourage, nurture, and assist in providing special grants to develop new rehabilitation counselor education training programs in minority institutions of higher learning.

2. The average percent of minority graduates over the last eight years in the U.S. is only 17.5%. RSA must increase the number of traineeship grants to universities to attract minority students in masters and doctoral programs, especially those with disabilities.

3. In order to develop a cadre of educators, researchers, and scholars, RSA grants should be targeted in developing doctoral studies.

4. RSA should take a proactive stance in assisting and implementing the recommendations made earlier for the state-federal VR system.

5. As an advocate, RSA must take an active part in incorporating the needs of ethnic minorities with disabilities in the ensuing reauthorization of the Rehabilitation Act.

Recommendations for NIDRR

1. Research and demonstration needs of ethnic minorities with disabilities should be given a national priority in the NIDRR funded research.

2. Implement research and demonstration projects in developing Afro-centric and ethno-centric models of: a. counseling, b. outreach, and c. service delivery.

3. Efficacy of service delivery by qualified rehabilitation counselors of same or different ethnic origins may be replicated across the country.

4. Develop a cadre of educators, researchers, and scholars who are ethnic minorities.

5. Utilize the expertise of ethnic minorities researchers and scholars in implementing NIDRR funded research and demonstration projects.

6. Provide special funding for masters thesis and doctoral dissertation research on issues of cross-cultural concerns.

In conclusion, a technologically advanced society as ours cannot advance further, leaving behind a staggering number of under-served populations or a segment of society who were traditionally being unserved. The "Melting Pot Theory" in America needs to be revisited with the "Cultural Mosaic Theory" in which the best from each culture or ethnic group will shine like precious gems and their combined glitter will replace the darkness of our minds, given adequate opportunity.

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Appendix
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Reaction to Vocational Rehabilitation of Minorities

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A review of the contents of the paper entitled "The Vocational Rehabilitation of Minorities" presented by Dr. Frank Giles indicates a crucial need for the Rehabilitation Services Administration (RSA) and the state/federal rehabilitation system to address the unique needs of "minorities with disabilities". The author clearly shows, with statistical data from the 1990 United States (U.S) Census Bureau records, that disabilities are disproportionately high among minority groups when compared with White Americans. In addition, there are demographic trends that illustrate that the number of minority persons with disabilities will continue to increase. As a result, there will be large numbers of minorities with disabilities of working age which will impact the RSA state/federal system. However, when the statistical data are closely examined, there are startling figures which illustrate otherwise.

Based on data from RSA along with data from the U.S. Census Bureau, there is a smaller number of minorities who: (a) have access to the federal/state vocational rehabilitation (VR) system; (b) move timely through the VR process and be rehabilitated with successful employment; (c) eligible for rehabilitation services, and (d) will not likely encounter a vocational rehabilitation counselor belonging to one of the minority groups.

The author explains why each minority group underutilizes the state/federal VR programs and why each minority group may be underrepresented. Several of the reasons are common to all of the minority groups, while others are unique to that particular minority group. Some of the reasons for the discrepancy in the statistical data concerning access and participation of minorities with disabilities in the state/federal VR program are that some: (a) members of the minority groups have a sense of mistrust and may demonstrate a lack of self initiative and commitment to VR services; (b) individuals from minority groups do not have sufficient or accurate information about VR services; (c) counselors have levels of lower expectations of members of minority groups (e.g. believe the disability does not represent a substantial barrier, with rehabilitation services will not lead to gainful employment, etc.); (e) counselor/client relationships are impaired by language and cultural

differences, racial/ethnic origin, migration vs. immigration and well as refugees vs. immigration, legal vs. illegal status and the amount of time spent in the United States; (f) possible recipients of services want to live in close proximity to services (lack of accessibility and availability i.e., rural areas, reservations, etc.); (g) individuals from some minority groups have close cultural and family connections and find it difficult to actively seek out societal services; (h) individuals from minority groups lack transportation to receive services as well as the ability to get back and forth to work if employed: (i) individuals from minority groups would like to be employed near their residences rather than far away; and (j) many of the VR counselors are White Americans and are not of a minority racial/ethnic origin.

In order for the RSA to address the unique needs of minorities with disabilities, the agency must reexamine its traditional approach to increasing the awareness of , understanding of, acceptance of, utilization of and commitment to VR services. However, it will take an action oriented commitment from RSA to mandate changes in the development and implementation of innovative nontradional delivery of services methods, such as, taking the services to the community, utilizing community leaders, including family support systems, etc.

Extensive field research needs to be funded by federal sources of qualified researchers who represent minority groups. These individuals would study the issues and develop assessment instruments to explore the issues with flexibility to include any additional issues identified in the actual field research. These instruments should be pilot-tested and designed to eliminate any barriers that may impede accessing this information. Methods of collecting information need to be concerned with the familial, cultural, community as well as language barriers. A thorough review of the collected research should provide information to develop and implement policies so that beneficial strategies and techniques can be created o influence more effective and efficient decisions concerning the: (a) location of services; (b) determination of eligibility for services; (c) movement of clients through the rehabilitation process; (d) matching of appropriate services to meet their unique needs; and (e) training (beyond awareness) for new and veterans rehabilitation personnel (i.e. from the federal level to the VR counselor) in working with individuals from diverse racial/ethnic groups. Hopefully, effective models can be developed for implementation.

There are several models which are available to improve service delivery and make services more available and accessible (i.e. Atkins' Asset-Oriented Model, Walker's Collaborative Model, etc.). These models, as well as any newly developed ones, should include both process and outcome measures.

There is also a shortage of qualified minorities working as professionals in the field of rehabilitation. The author states that among the institutions of higher learning, only about 15.8% of all graduates from rehabilitation programs are minorities. Also RSA must further expand its commitment to recruit more individuals from minority groups into rehabilitation counseling programs with training in multicultural counseling. To assist RSA in addressing the multicultural

issue, the agency should work with the Council on Rehabilitation Education to develop mandatory guidelines which will be implemented in the training programs to assure appropriate and adequate training of qualified rehabilitation graduates. RSA already has one vehicle to increase the number of qualified minority rehabilitation professionals. Several rehabilitation counseling programs are located in Historical Black Colleges and Universities (HBCUs). These institutions of higher learning are in a good position for RSA to provide funds for: (a) supporting the rehabilitation programs; (b) developing new rehabilitation programs; (c) providing funds for recruiting and maintaining more minorities; (d) including employment strategies so that more minorities will be hired into and promoted in the federal/state rehabilitation systems; and (e) creating incentives to increase the number of rehabilitation educators as well as professionals on the federal level and in state administrative positions. RSA must demonstrate that minorities must have a place in the field of rehabilitation from top federal administrative positions, where policy is developed, to rehabilitation professionals who supervise the administration of service delivery, to personnel who delivers direct services. In addition, all professionals in the field should be required to participate in extensive and continuous multicultural counseling. It is not just an awareness or a one time experience. Society changes with the times; therefore, it is important that all rehabilitation professional/personnel be prepared to work with individuals from diverse racial/ethnic populations.

There is limited information when comparing the state/federal VR programs and the private-for-profit system when focusing on the aforementioned issues relevant to minorities with disabilities in rehabilitation. Until more detailed research studies have been conducted to make adequate and appropriate comparisons only unconclusive results will be available. However, there is some data which can be used to make some limited statements about the two systems. Therefore, it is premature to develop meaningful comparisons which can be used to determine the effectiveness of each system.

The theme of this conference is "The Unique Needs of Minorities with Disabilities: Setting an Agenda for the Future." However, in reviewing this paper it is apparent that the rehabilitation field is not ready for 1995. There is a probability that the profession could be ready for the year 2000, but the field of rehabilitation must accept the challenge to be proactive rather than reactive.