DOCUMENT RESUME

ED 387 994 EC 304 349

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TITLE Operationalizing Consumer Decision Making and Choice in the VR Process. Institute on Rehabilitation Issues (21st, Baltimore, Maryland, March 1995). Report from the Study Group.
INSTITUTION Wisconsin Univ.-Stout, Menomonie. Stout Vocational Rehabilitation Inst.
SPONS AGENCY National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE Mar 95
CONTRACT H133B80049-90
NOTE 129p.
AVAILABLE FROM University of Wisconsin-Stout, Rehabilitation Research and Training Center, Stout Vocational Rehabilitation Institute, School of Education and Human Services, Menomonie, WI 54751-0790 ($18.25).
PUB TYPE Collected Works - Conference Proceedings (021)

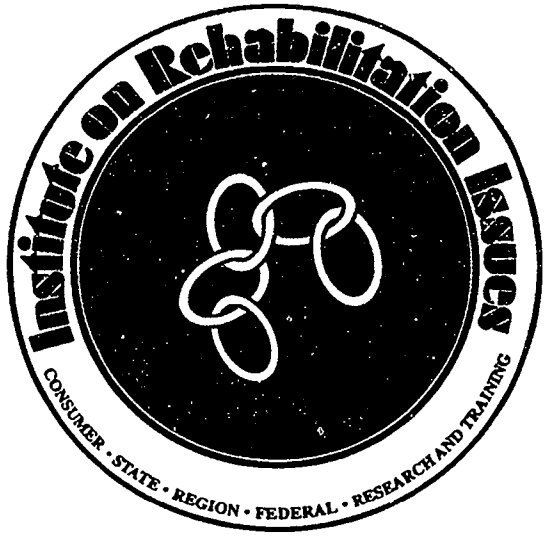
EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS Adults; Change Strategies; Consumer Education; Counselor Role; *Decision Making; Delivery Systems; *Disabilities; Independent Living; Participative Decision Making; *Personal Autonomy; Program Development; Rehabilitation; *Rehabilitation Counseling; Social Services; *Vocational Rehabilitation
IDENTIFIERS *Consumer Participation; *Informed Consent

ABSTRACT

This document is the product of meetings of the Prime Study Group of the Institute on Rehabilitation Issues, whose mission was to: examine consumer choice and decision making in rehabilitation; review the legislation and consumer movements leading to greater consumer choice; identify the roles and responsibilities of the consumer, the counselor, supervisors, administrators, and others in the vocational rehabilitation process; and consider how to operationalize the process of consumer choice and involvement. Chapter 1 focuses on the concept of "consumer informed choice," noting the counselor's changing role, the consumer-counselor partnership, and benefits of consumer informed choice. Chapter 2 provides background information on the evolution of rehabilitation as a social program, reasons for social change and demand for rehabilitation reform, and the change process. Chapter 3 focuses on the roles and responsibilities of various stake-holders in the informed-choice process. Chapter 4 considers how to operationalize the process. It discusses when the process occurs, the importance of counseling in implementing informed-choice, counselor skills, a case study involving choice issues, documentation, strategies to empower the consumer and reduce conflict, pilot projects, and program models. Attached are a glossary and two article reprints by Thomas Czerlinsky and Shirley Chandler, titled "Effective Consumer-Service Provider Interactions in Vocational Rehabilitation" and "Empowerment Counseling: Consumer-Counselor Partnerships in the Rehabilitation Process." (Contains approximately 90 references.) (DB)

TWENTY-FIRST INSTITUTE ON REHABILITATION ISSUES

Operationalizing Consumer Decision Making and Choice in the VR Process



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March, 1995

Report from the Study Group on

Operationalizing Consumer Decision Making and Choice in the VR Process

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Twenty-First Institute on Rehabilitation Issues

Baltimore - March 1995

The contents of this IRI document were developed under a grant (H133B80049-90) from the National Institute on Disabiiity and Rehabilitation Research of the Department of Education and the Rehabilitation Services Administration. However, these contents do not necessarily represent the policy of those agencies, and you should not assume endorsement by the Federal Government

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Foreword

It is generally recognized and acknowledged by people with disabilities, legislators, rehabilitation professionals, and the general public that the state-federal program of vocational rehabilitation has been one of the "gems" in our country's social legislation programming Most would agree that vocational rehabilitation is a program that reaches the majority of its objectives while continuing to improve and widen its services to people with disabilities.

Within this very successful program, however, there is an awareness that the people with disabilities whom the program is designed to serve have often had a limited voice in the direction of their own vocational rehabilitation planning. It's probably safe to say that the relationship between the rehabilitation counselor (and other rehabilitation professionals, for that matter) and the client/consumer has not always been a true partnership - that is, a partnership in which the consumer has had significant opportunity to make decisions and informed choices in the direction of his/her rehabilitation future.

This area of consumer choice is the topic of this document. The charge to the IRI Prime Study Group was to examine the question of what is consumer choice and decision making; review the legislation and consumer movements leading to greater consumer choice; identify the roles and responsibilities of the consumer, the counselor, supervisors and administrators, and other partners on the vocational rehabilitation process; and finally, how to operationalize the process of consumer choice and involvement in decision making.

Multiple copies of this document have been disseminated to each state vocational rehabilitation agency for staff and consumer information and training. In addition, copies were sent to rehabilitation educators, professional rehabilitation organizations, rehabilitation resources, and a variety of other interested parties. We invite your comments and suggestions.

Acknowledgements

Readers often see a paragraph or two in the front of books called "Acknowledgements." Typically, "acknowledgements" list people who "helped and assisted...". Viewed in that way, the word "acknowledgements" doesn't really reflect the real role and contribution of the members of this Prime Study Group. These individuals were not simply "helpers" or "consultants" or people invited to provide occasional input. They were, in fact, the real authors who did the thinking, critiquing, writing (and re-writing) of 100 percent of the body and content of this document. They were the people who had the "real rehabilitation world" experience to draw upon and who had the ideas about how consumer choice could be made to happen.

The IRI staff wish to make it very clear that the credit for this timely and important document belongs to the members of the Prime Study Group. Our roles in this process were to organize the meetings, edit and compose the document, and finally, arrange for the printing and distribution. In other words, our roles were really secondary to the much more difficult work of creating the content of this document. We wish to recognize that fact and to thank the Prime Study Group for their outstanding effort.

We wish to also recognize and thank Ms. Jean Davis of our Research and Training Center clerical staff. Ms. Davis is the person primarily responsible for composing this (and many previous) IRI documents. Her word processing skills, knowledge of formatting and APA style, and her attention to details are the primary reasons that attractive and accurate IRI documents result.

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Chapter I

What is "Consumer Informed Choice"?

It is the policy of the United States that programs under this Act be carried out in a manner consistent with the ... pursuit of meaningful careers, based on informed choice of individuals with disabilities (§2(c)(1)) ...[and that] individuals with disabilities must be active partners in their own rehabilitation programs, including making meaningful and informed choices about the selection of their vocational goals and objectives and the vocational services they receive (§100(a)(3)(c)). (The 1992 Amendments to the Rehabilitation Act of 1973)

Introduction

This chapter describes informed choice as a process in which consumers share mutual responsibility with counselors in identifying options and considering the advantage and disadvantage of each from the consumer viewpoint. Given the facts, the consumer makes informed choices toward a meaningful career. The process occurs within the context of a partnership where each partner has equal status and shared responsibility for the process and outcome. The issues facing counselors and consumers as they transition to these new roles are described. A list of the benefits to the consumer, counselor, and society as a result of this changed relationship and decision making is provided.

Informed Choice and the Counselor's Changing Role

Vocational rehabilitation is in transition. The way we've always done business doesn't seem right any more. The vocational counseling model of "we tell, you do" is out of date. New terms and concepts are in the law, and consumers are speaking out and demanding something different. It is a time of change, and change seldom comes without questioning, uncertainty, and some anxiety. Where we're going or are supposed to go is not clear; we only know that, if we don't change, we may become a footnote in history.

One thing that does seem clear is that, for vocational rehabilitation to be a viable, relevant program, it must be shaped *with* the support of people who use those services. It simply can't be accomplished with an attitude of "we'll do it *for* them."

So, what is "consumer informed choice" and where does it fit in? Informed choice is the outcome of a process that occurs within a partnership where the partners identify and explore together the various options at each decision point in the consumer's rehabilitation, where the positive and negative implications from the consumer's perspective are identified, and where the counselor provides support as needed for the consumer to make the informed choices that will result in a meaningful career outcome.

The dictionary defines "informed" as "making use of information ... based on factual knowledge" and "choice" as "the act of choosing, selection ... the power, right, or liberty to choose; option ... a number or variety from which to choose ... something that is best or preferable above others ... an alternative."

The people we are meant to serve may be ahead of us in their preparation to make informed choices. Rehabilitation counselors need to catch up. If we approach our relationship with our consumers as team members—partners—each with something equally valuable to offer, the result can be rewarding to both. More importantly, the results may be far more meaningful than if either partner tried to do it alone or took a dominant or subordinate role. Consumers who approach vocational rehabilitation from the perspective that "they have all the answers" may never know what some options may have been. Rehabilitation counselors who approach the relationship with consumers from the viewpoint of "I have all the answers" may sadly miss the consumers' dreams.

So, what does this mean for the rehabilitation counselor? There may be some catching up to do. What we learned in college in our orientation to our roles and responsibilities, and through our experiences on the job, may be out of sync with what is needed today.

Does this mean rehabilitation counselors may need to unlearn everything they learned about how to do counseling? No—basic counseling skills are very much the skills needed today—person-centered ("you really cared about that person"); empathic ("that really made you feel hurt"); facilitative ("how would you describe the problem?"); helping consumers get in touch with their feelings ("how did that make you feel?"); and problem resolution. The irony is that, historically, we often didn't use these same basic counseling skills when it came to *vocational* counseling. Then we often switched roles and, in effect, may have assumed an all-knowing, albeit well intentioned attitude. We generally rarely questioned whether we were wrong and/or what was right, or, if we did, we usually consulted with our supervisor or another counselor or professional. Seldom did we ask what the consumer thought (although we've grown in that respect). We weren't deliberately avoiding the consumer; we would never have entered a helping profession if we had that mindset. No, we simply had been trained to believe it was our responsibility to have all the information, all the answers, and to tell or inform our consumers what was best for them, given all the information we'd gathered about them and the resources available.

What we really need to do now is be sure that we are approaching our consumers with an open mind rather than one full of preconceived ideas and ready answers. We can use our valuable counseling skills to help the consumer explore options, work through trouble spots and support consumer decision making in a partnership approach to rehabilitation. Within the vocational rehabilitation program most of us are familiar with the latest management theories about team work. Most of us probably have served on an ad hoc team, quality team, management team, cross unit/division team, planning team, community development team, or what have you. What is needed is to carry over these skills to our interactions with consumers for a good partnership.

Counselors are working with consumers at a time of change in the consumers' lives. Change creates anxiety for consumers. Consumers may not like where they're at, but it is a

"known," and if they can't be sure what the future may bring, at least the known brings a certain measure of security. It's like taking a giant step across a chasm of unknown depth. They are not sure they will make it, or if they do make it, whether they will like it there. It's giving up familiar faces, places, and routines which, even if they don't like them, provide security. It's ending one chapter of life and exploring the transition of rehabilitation where new things are tried, information is gathered, chances are taken, and tough decisions are made. It's risky. Consumers really don't know how all this will turn out. At times the risk may just seem too great, uncertainty too anxiety-provoking, and the consumer may back out to return to familiar safety. Other consumers diminish risk by leaving all decision making to counselors. If there is no ownership associated with decisions, then there is no responsibility for outcomes. If decisions turn out okay, that's good, but if they do not, then the consumer does not have to assume the fault.

Counseling and guidance may be the most meaningful services the vocational rehabilitation counselor has to offer - not just services arranged or coordinated through other agencies (though those can be important), not just paying for services (an account clerk can write a check), but providing the encouragement, support, problem resolution, and encouragement to seek out options and take risks and providing a safety net if early efforts do not work. Learning how-to-do-it-yourself-the-next-time the rehabilitation counselor brings to the relationship is *really* what counts most. Counseling and guidance skills have been too long an overlooked or "secret" vocational rehabilitation service! It is probably fair to say that most counselors are not aware of and/or appreciate the value of what they personally bring to the partnership.

Many consumers are ahead of counselors in preparing for their partnership role. The independent living movement has been a big help in getting more and more individuals with disabilities to recognize that they *can* control their own lives. Consumers have equal rights to participate fully in the American way of life and to enjoy its benefits. They no longer have to accept a society in which they are not actually allowed to be part of living, working, mingling with others, and enjoying the same things as everyone else. The Civil Rights movement taught us that the American dream is one in which all people have an equal right to the pursuit of happiness—to be an equal and fully participating partner in making choices that collectively are the "American Way." People with disabilities were late to the "rights" movement, but they have been just as powerful as other disenfranchised groups in gaining recognition for their rights.

Vocational rehabilitation professionals should be active champions of equal rights for people with disabilities. We should be strong advocates of the Americans with Disabilities Act. We must continue to advocate in our local communities to ensure accessible transportation, parking, housing, public buildings, and street crossings. Our talk of empowerment early on, however, was usually more in terms of empowerment for agency staff. There was talk of empowering consumers, too, but without much consideration for what this really means in practice. It wasn't until the 1992 Amendments to the Rehabilitation Act that we were forced to take a hard look at how we do business.

Our consumers, in the meantime, were being prepared for their new roles through self-advocacy, assertiveness, and other training often offered by Centers for Independent Living or offices for students with disabilities at colleges and universities. Advocacy agencies and mainstreaming in special education also helped to enhance the awareness of people with

disabilities of their rights and how to exercise them. At home, too, parents of children with disabilities have been encouraging them not to settle for less. The last four letters of "American," after all, spell "i can" (an illustration provided by the 1994 Miss America, Heather Whitestone, a person who is deaf).

So, while our consumers have been preparing to be partners with us, to be empowered to make choices, vocational rehabilitation agencies often have not done much to prepare counselors for this new relationship. While we are supporters of the larger movement, we may not have been thinking nor doing very much about this from a practical, operational standpoint. Many consumers may have a better idea of what this means than we do as we go about our daily tasks of providing rehabilitation services.

So what does all this mean? It means we have a job to do. Not only do rehabilitation educators need to update their curriculums, state agency administrators may also need to update the knowledge and skills of counselors already in the field. We need to be sure that we know how to be a partner in an informed choice model.

Change can be as anxiety-provoking for counselors as for consumers, and people need to understand this. Much of what we've been taught and how we've done our job is being challenged. Even the term used to describe the individuals served by vocational rehabilitation agencies is changing. An accepted term today besides "consumer" is "customer" rather than "client." We do recognize and accept the values inherent in using the term customer, but it may lead to confusion and questions. According to the dictionary, a *customer* is one who receives goods or services from another, usually for a monetary exchange. A *client*, on the other hand, is a customer who receives services from a professional. So, does the shift to the term "customer" unwittingly undermine the significance of our role as a counselor? If the client is now a customer, does that mean we as counselors are now no longer considered professionals? And what about the 1992 Amendments which emphasize that state vocational rehabilitation agencies be staffed by the highest level of qualified professionals possible? It's a real dichotomy, or so it seems.

No wonder that there is uncertainty about our role. Despite the confusion and questions, we should be sure what we are doing is focusing on the values, attitudes, and behaviors that are to be encouraged and not let terms interfere. Just as we encourage consumers to believe they have worth, a right, and a need to be active partners in their rehabilitation, many of us too may need support as we work through a possible identity crisis. Some of us may need to be reassured that we are professionals as evidenced by our years of academic training, in-service training, and the valuable experience we bring to the consumer-counselor partnership. We have unique skills and need to know that we are still needed and important. The change for us is not on *what* we do but *how* we do it—and that's what this document is about.

Some of us, it is true, may experience concern when contemplating the possible consequences of a partnership with the consumer. Many of us find change of any sort unsettling. But change is inevitable and can be a positive event. There is no doubt that our skills as professional vocational rehabilitation counselors are greatly needed if consumers are to fully enjoy the benefits of informed choice. We must be there to provide floors and walls for the consumers, but never ceilings.

Informed Choice: A Consumer-Inspired Concept

Americans with disabilities share with other citizens the desire to realize fully their potential in the pursuit of meaningful careers that allow them the opportunity to participate completely and freely in day-to-day community life. Despite the best efforts of many, and the expenditure of considerable resources, the objectives of meaningful employment and integration into society have yet to be fully achieved. The plight of people with disabilities was underscored by Congress in the Rehabilitation Act Amendments of 1992, which state that:

> As a group, individuals with disabilities experience staggering levels of unemployment and poverty. . . . [the] reasons for a significant number of individuals with disabilities not working, or working at a level not commensurate with their abilities and capabilities, include . . . lack of education, training and supports to meet job qualification standards necessary to enter or retain or advance in employment. (The Rehabilitation Act of 1973, as amended §100 (a)(1)(B) and (D)(iv)).

If this situation is to be improved, a shift in the counseling model must be undertaken in which the counselor and consumer strive to work in concert for more positive outcomes. At the heart of this new model is the concept of informed choice. By planning *with* consumers, rather than *for* them, we can create partnerships that are mutually beneficial.

The Rehabilitation Act Amendments of 1992 (§102(b)(1)(B)(i)) state that each Individualized Written Rehabilitation Program must be "consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities, of the individual." But true "informed choice" is a more important concept that can greatly impact the positive search for a meaningful career for the consumer. It should begin with the first meeting between the consumer and counselor and continue throughout the rehabilitation process with provision for whatever accommodations are needed to make this a meaningful experience and to forge a real partnership. A rough parity must be maintained between ourselves and consumers during the decision-making process; otherwise, there is a danger that consumers will be treated in a less than equal manner.

The Rehabilitation Act Amendments of 1992 also state that the employment objective must be based on a comprehensive assessment, "including an assessment of career interests for the individual" (§102(b)(1)(B)(ii)) with an emphasis on the use of existing information and;

> such information as can be provided by the individual and, ... to the degree needed ... an assessment of the personality, interest, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational attitudes, personal and social adjustments, and employment opportunities of the individual, and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors, that affect the employment and rehabilitation needs of the individual. (§7(22)(B)(ii) and (iii))

It is during the comprehensive assessment that we lay the groundwork for an Individualized Written Rehabilitation Program (IWRP) that reflects the strategies to be pursued towards meaningful career options for the consumer. By thoroughly involving the consumer in the rehabilitation process, a consumer driven model of service provision will replace the system driven model of the past. Such a transition would be in keeping with changing concepts and attitudes that have been sweeping through the "disabled" community for some time. Since language is a powerful tool for shaping thought, one need only note the new vocabulary, concepts, and attitudes to realize the break that is being made with the past.

Changing Times

What's In	What's Out
• Asking	• Telling
• Shared information gathering	• Counselor does/knows all
• Equal partners	• Senior-junior partnership
• Exploring dreams	• Cold practicality
• Considering all the options	• Counselor presents only the "best" option
• Weighing the options from the consumer's perspective	• Counselor knows best
• Maximizing potential	• Underemployment
• Consumer owns the decision	• Counselor drives the decision
• All the facts	• Some of the facts
• Shared responsibility	• Responsibility is primarily the counselor's
• Positive thinking—"You can do it."	• Negative thinking—"These are all the reasons you can't do it."
• Questioning	• Having all the answers
• Activity	• Passivity
• With	• For
• Empowerment	• Dependency
• Ownership	• Acquiescence
• Assertiveness	• Submissiveness
• Consumer	• Client
• Sensitivity to diversity	• One model fits all
• Guidance towards careers	• Prescriptive medical model
• Meaningful career	• Dead end jobs
• Partnership	• Patriarchy

It is our responsibility to ensure that the opportunity for informed choice is available to the consumer. We can do this by encouraging the consumer to provide input throughout the rehabilitation process beginning with the intake interview. This may be challenging to both parties, especially if the consumer has remained in a state of dependency for many years and lacks assertiveness or confidence. The counselor may have to help the consumer develop the skills and confidence needed to be a partner.

There are many ways to enhance the consumer-counselor partnership. For example, we should discuss with the consumer the types of evaluative instruments to be used, as well as their results. Consumers must be helped to the extent needed to become conscious of and knowledgeable about their skills, abilities, talents, and interests and how these relate to the selection of meaningful career options. The pros and cons of various career paths must likewise be explored and, of course, with considerable care and research. Other important and significant people in this process may include advocates, mentors, parents, friends, and peer counselors.

If individuals with disabilities are "to be all they can be," a holistic approach must be taken. Informed choice must be made within the context of the consumer's entire situation, including socio-economic considerations, personal relationships, and an understanding and acceptance of the disabling condition. In addition, professionals must have the ability to properly evaluate information and then present that information to the consumer in an accessible format and in language free from confusing acronyms and professional jargon.

With the concept of informed choice as the basis for identifying a career that offers growth and mobility, the individual's expectations and aspirations are improved. The positive shift in emphasis towards long-term goals that consumers desire should increase their level of satisfaction.

The consumer-counselor relationship should be one of shared responsibilities. Our role as professional counselors, with knowledge, skills, and expertise, is to provide a wide array of guidance and counseling services. Consumers have an equal responsibility to contribute time and effort in gathering relevant career data to the extend of their abilities to do so.

The Consumer-Counselor Partnership

In order to maximize the benefits of partnerships with consumers, consumers must be allowed to exercise informed choice when deciding upon meaningful career options and also strategies for implementation of these choices.

This task is not easy, but the potential rewards can be considerable. The consumer should participate in the comprehensive assessment with the counselor in identifying career paths that are meaningful to the consumer. We must help to explore the consumer's talents, abilities, interests, skills, knowledge, priorities, career possibilities and employment outcomes. Goals and alternative career-seeking strategies should be developed. These should be based on a clear rationale, supported by substantive facts, including job availability, long-term occupational outlook, training requirements, and possible levels of pay and benefits. Much of this

information gathering may be able to be done by consumers after ensuring they are prepared and ready to do so. Given this information and the professional guidance we provide, consumers will then be in a good position to make informed choices.

Sometimes a consumer may not be ready to participate in a partnership of equals and may, in fact, be confused as to what to expect from vocational rehabilitation. One study found that among 235 persons interviewed, 38.6% said they didn't know what vocational rehabilitation was supposed to do. (Neal, 1984.) Consumers must become knowledgeable of the vocational rehabilitation system, the concept of informed choice, and what rights and responsibilities they have. Achieving these objectives requires consumers to possess decision-making skills, self-motivation, and the ability to inform professionals on personally meaningful career opportunities and their ability to achieve them.

The model of the lawyer and client jointly preparing a Last Will and Testament may be helpful to illustrate the consumer-counselor relationship. The lawyer's role is to provide advice and guidance to a client who is interested in the preparation of a Will. The assets involved all belong to the client, as does the final decision on allocation of assets. The lawyer educates the client about the law; the client educates the lawyer as to what should be done with the client's resources, and together they draft the document.

To promote informed choice, we have the task of *guiding* the consumer towards the selection of a meaningful career path and *counseling* the consumer as to how these objectives might be achieved. The distinction between "guidance" and "counseling" is an important one and has been defined by the Twentieth Institute on Rehabilitation Issues (1993) as follows:

> Counseling is the process whereby two individuals, (i.e., the consumer and the counselor) collaborate to identify, prepare for and achieve meaningful vocational outcomes for the consumer. It is a process that may entail extensive discussion, planning, exploration, and clarification of values, needs, desires, and realities facing both partners in the rehabilitation relationship. "Guidance" services are uniquely individualized within the rehabilitation relationship and primarily involve providing information. It is advice driven. However, counseling services may also be needed to integrate or reject the information or advice provided. . . Guidance skills, as well as counseling skills, are critical to the process if the outcome is to have a reasonable chance for success.
>
> Counseling, as differentiated from guidance, is the process that may be needed when clarification of values and other issues become a part of the decision-making process for the consumer. (Twentieth Institute on Rehabilitation Issues, Nov. 1993, p. 2.).

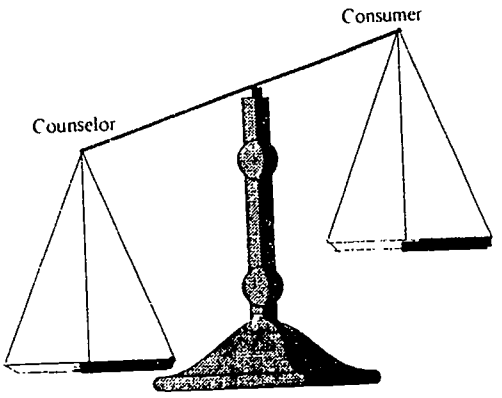
Our role is critical in assisting consumers to become job ready and in guiding them to prepare for careers that provide for growth and mobility; our professional experience, knowledge, skill, and expertise are invaluable resources for the consumer. The general store of knowledge we possess remains valid and useful despite the rapid changes sweeping the world of work today.

Most of us have worked with consumers with a wide range of disabling conditions and cultural backgrounds. This experience can provide us with a holistic view of the process of guidance and counseling. By focusing on the entire person and the positive aspects of the situation as partners, we can then focus on the consumer's "dream" rather than the disability.

This does not mean that we may not say "no" when it is appropriate to do so. Our role is not simply to be there with an open checkbook. Consumers must be assertive in stating their wishes, but we must be prepared to set financial parameters, challenge ideas when necessary, and provide reality checks on a regular basis.

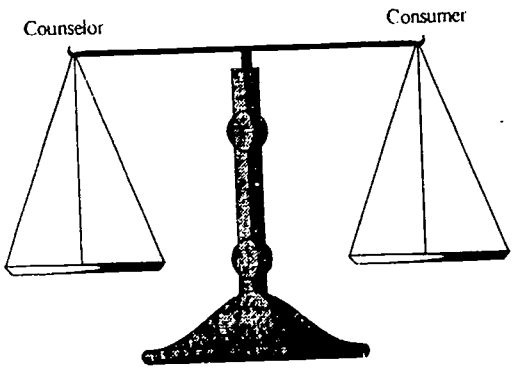
Balance

The Consumer-Counsleor Relationship



Before

The counselor carried the weight



After

The weight is balanced

Although the consumer forms the heart of the partnership in the rehabilitation process, a broader coalition of other individuals may be involved in varying degrees. Parents, guardians, significant others, and, depending on the cultural background of the consumer, important community representatives may also play a part. Advocates, peer counselors, and mentors may be directly or indirectly involved in various aspects of career identification and planning. Staff from a Client Assistance Program can also be a valuable resource to the consumer in clarifying agency policies and providing support to the consumer in making informed choices.

Sometimes we may find it necessary to expand the partnership to include outside agencies and institutions such as schools, Independent Living Centers, and vendors of contracted services. The consumer should be involved in an informed choice process to determine and evaluate the scope, impact, and quality of the services of these resources in the formulation of career options and plans.

Benefits of Consumer Informed Choice

In recent years there has been an evolution of social program objectives that increasingly centered around the consumer's experience. This has been accomplished in part by the formation of consumer advocacy groups. The trend towards consumer empowerment is not unique to the community of people with disabilities, but it also has been occurring in many other segments of society. An informed consumer, whether requiring medical, legal or rehabilitation services, seems easier to work with and potentially more likely to be satisfied than one who feels no ownership in the process.

With greater participation in preparing for their careers, customers' recidivism rate may be reduced because "dead end" job placements should decline. The consumer, as an active member of the rehabilitation partnership, will have conducted research on a variety of career options and will be able to share this knowledge with their professional partners. Many skills the consumer will learn to use, such as decision making, will be of life-long value. But beyond the cost effectiveness of closing more cases successfully rehabilitated, and fewer consumers returning after unsatisfactory work experiences, is the prospect that meaningful career options based on the informed choice process gives the consumer the best chance at achieving the American dream.

For rehabilitation professionals, informed choice holds the possibility of spending less time overall with each consumer. Consumers who are pursuing personally meaningful careers, rather than dead-end jobs, will be less likely to return for further assistance. We don't know yet how much time we will need to spend with consumers while assisting them in exercising informed choice, but what is expected is that, since consumers will be sharing the responsibilities especially in the area of information gathering, our overall work burden should be reduced.

As more successfully rehabilitated case closures occur, and more people with disabilities are represented in a wider variety of occupations, the task of job placement should become easier. More placements may provide a greater pool of role models, potential mentors, and peer counselors. Additionally, as more and more individuals with disabilities enter competitive

employment and leave public assistance, society as a whole will benefit by the addition of talented and capable people to the work force. It is a recognized fact that dollars spent in rehabilitating an individual are returned to society many times over in the form of taxes paid by working citizens.

The promise embodied in the informed choice provisions of the 1992 Amendments to the Rehabilitation Act lies in the fulfillment of that reality. Active participation at every stage of the rehabilitation process helps ensure that rehabilitation plans will be realizable because they will mix our expertise with the expertise and commitment of the consumer in a joint effort toward a common goal. Individuals with disabilities can be expected to strive for achievement of that goal because it reflects their own aspirations.

Informed choice can be seen as an exciting value added to the rehabilitation process. For the first time the consumer clearly must share in the decision making. Even though the purpose of the IWRP has always been to do this, too often it was developed based on counselor expertise. Informed choice can validate the idea that persons with a disability have expertise and a vested interest in the rehabilitation outcome and should have an opportunity to act on these.

One important result of informed choice is the transferring of some of our responsibility for vocational planning to our consumers. No longer do we need to be concerned about developing an IWRP that is agreeable to the consumer, since it will now be based upon the informed choices of the consumer. This may expand the range of vocational goals as consumers actualize their individual aspirations. The challenge will lie in finding the appropriate resources to meet the needs.

Improved customer satisfaction can be expected as an added bonus to successful implementation of informed choice. The number of complaints about being inappropriately "fitted" to vocational objectives not of the consumer's choosing should decline, and the number of success stories from consumers striving for and reaching goals of their own choosing should increase.

Recidivism too may decrease since consumers will be placed in employment they have helped choose and through services provided according to their needs as they perceive them. The quality and longevity of successful closures should rise accordingly.

CONSUMER BENEFITS

The consumers will:

- Have more information necessary to make valid decisions and take *control* of their life
- Share responsibility, resulting in more varied and meaningful choices.
- Become *active partners* in shaping decisions that in turn shape their lives.
- Learn decision-making skills.
- Learn about options -- that there are usually many -- that sometimes you really have to search for them—that there are choices in rehabilitation as well as in life.
- Learn that each option, each choice will have a different impact, meaning, and result, and should be weighed carefully.
- Learn that, when selecting among options, it's what makes best sense from their perspective, and maybe their families, that determines the decision.
- Be better able to resolve their own problems and make their own life choices in the future.
- By involvement in their rehabilitation, will gain a better understanding of the rehabilitation process.
- Gain a better understanding of their own needs, strengths, desires.
- Gain in self-respect from being considered informed, knowledgeable partners by their counselor.
- Learn not to be concerned that their diverse needs due to disability, race, gender, or religion will not be understood and valued—*that these are important and enrich the rehabilitation process.*
- Learn that it's okay to speak up—*that what they have to say is important and will be listened to.*
- Gain in self-assurance and ability to be self-advocates.
- Gain in pride about their rehabilitation plans because of their meaningful participation in creating them.
- Learn that sometimes one has to stretch—work hard—be tough in order to achieve one's goals —that what one wants won't come if one doesn't help make it happen—that this is part of being an active partner.
- Be apt to have a more satisfying, better paying job with greater benefits and job security as a result of exploring all options toward the goal of getting the most out of their capacities.
- Learn **it's okay to have dreams and that often you can even make them come true!**

COUNSELOR BENEFITS

The counselor will:

- Experience more successful rehabilitations because consumers who have learned how to make their own informed choices are less likely to be "repeaters."
- Find an increased likelihood that consumers will follow through on the activities in their rehabilitation plan, since they were the ones who chose them.
- Find the job possibly easier by sharing the responsibility for information gathering and exploration.
- More likely encounter consumer satisfaction.
- Be reassured that professionalism is highlighted through the recognition that guidance and counseling skills and knowledge are valuable to the partnership.
- Understand their consumers better since, as partners, consumers are more creative—much less passive—in working with the counselor in developing and carrying out rehabilitation plans.
- Find that sharing the responsibility reduces the burden and may help reduce job stress.
- Experience more fun—challenge—stimulation—rewards.
- Find that consumers better understand the rehabilitation process, reducing confusion and saving time.
- Encounter greater job market opportunities as satisfied consumers become satisfied employees, leading to satisfied employers interested in "repeat business."
- Probably experience fewer consumer appeals of decisions about their rehabilitation programs—i.e., the decisions are shared and thus the consumer is less likely to have reasons to appeal.
- Benefit as satisfied consumers spread the word, and good things happen from that—everything from enhancing agency image to writing Congresspersons in support of rehabilitation legislation and funding.
- Be rewarded with the good feeling that comes from experiencing consumer growth in decision making, reaching for dreams and achieving them.
- Experience increased job satisfaction as more consumers achieve first class rehabilitation outcomes.

WE ALL BENEFIT

Anything that benefits consumers and counselors has the net effect of benefiting society as a whole. These benefits may be indirect but are nevertheless there. We are already familiar with many of them.

- Active, involved people taking responsibility for their own life decisions are apt to be better citizens—being concerned with the issues that affect them, voting, paying taxes.
- People with *jobs* and *good benefits* add not only to their own net worth but to that of the country—we are all richer for it.
- Satisfied people are more pleasant to live with than those who feel disenfranchised.
- The mosaic of cultures, nationalities, religion, and color blending our society is further enriched when people with disabilities become active participants.

Chapter II

Background to the Emergence of Consumer Choice as Central in Rehabilitation

Introduction

In this chapter we will help you develop your understanding of how increasing consumer participation in advocacy and how successive changes in rehabilitation and related legislation have converged for greater consumer choice and informed decision-making.

The chapter begins with a discussion of how rehabilitation has evolved as a social program, including the parallel development of advocacy and rehabilitation's changing focus from a prescriptive process to its present form. We next examine the most critical reasons for the changing authority or ownership of rehabilitation, including the most significant forces driving this shift toward true consumer control. Next, we depict how rehabilitation is becoming a real partner in response to demands for reform. Finally, the authors suggest how consumer choice can be logically promoted through the values and practices of rehabilitation and why we really should embrace informed decision-making as basic to our rehabilitation program.

Evolution of Rehabilitation as a Social Program

> *"The rise of persons with disabilities as a group interested in its civil rights represents a more fundamental change than other ... [changes]. Planning needs to recognize this."* (Edward Berkowitz, 1984)

The national rehabilitation program in the United States came about in 1916 to meet needs of returning veterans who were seriously impaired during war. The program was for veterans, designed to respond to consequences of their physical disabilities, stressed physical restoration, and included a significant involvement of the technology of prosthetics. Scope and responsibility for the rehabilitation program increased as the economic needs of these persons became increasingly apparent, and vocational needs came to be given significant attention in conjunction with their medical problems. Responsibility for rehabilitation was shared among the medical providers, the veteran's programs, and other agencies involved in employment and public welfare for veterans unable to take care of their own needs. Delivery of rehabilitation, though, continued under a medical model.

In the 1920s the program expanded to include non-veterans as "clients" and began to address needs of industrially injured persons. In the late 1940s and 1950s the program began to include persons with other life-limiting and life-threatening neurological, physical, and systemic disabilities as appropriate for services. Simultaneously, we began to see the emergence of a federal-state rehabilitation program with eligibility requirements and clearer reference to a

"national program" in federal legislation. The focus of the program remained on "restoring and returning" the individual to gainful employment. The population continued to be adults, particularly adults with prior employment histories.

American ingenuity and success in industrial production were paralleled in the national thinking about "a system of rehabilitation," complete with eligibility requirements and a status approach to rehabilitation: The system was modeled in part after the medical model (diagnose, repair, rehabilitate) and in part after the industrial model (design, engineer, sequence, produce adapted persons). This national system of rehabilitation came to be largely divided into four parts:

1. A national agency with responsibilities for establishing regulations for a national rehabilitation program; for providing basic funding for rehabilitation services, research, and professional training; and for linking relevant resources to achieve Congressional intents;

2. A state program responsible for identifying, counseling, and coordinating the rehabilitation for persons with disabilities;

3. A medical provider sector with responsibility for identifying the extent of disability and basic needs of individuals who were severely affected and thus eligible for the state rehabilitation programs; and

4. A vocational provider sector with dual responsibilities for assessment, training, and either temporary employment for persons with "fixable" disabilities or for long-term employment (or day care) of persons with "intractable" disabilities.

The federal government provided strong leadership during this period under the Department of Health, Education, and Welfare. It was backed by hard-fought-for funds by the U.S. Congress for a program that had clear policies about who would become eligible to receive services. Individuals with significant influence in Washington made dramatic impacts in the shaping of the program (e.g., Mary Switzer), and the program shifted from a focus on medical restoration and came to be classified as a vocational rehabilitation program. Part of the program found its place in state governments (typically, in state education labor agencies) and sought to identify what was required to rehabilitate the client and what would be allowable under this eligibility program.

Medical diagnosis continued to determine eligibility for the program and in many respects continued to determine the course of rehabilitation for the "target populations" served by the program. Cause or origin of disability diminished as a concern (e.g., war injuries) under the evolving program, and the range of populations considered eligible for it expanded throughout the 1960s and 1970s. Populations eligible for the program included the developmentally disabled, alcoholics, public offenders, special populations (e.g., disadvantaged minority persons, youth with emotional and legal problems), mentally ill, children, school-age youth, and those affected by cardiovascular diseases. The language of disability emphasized "groups of individuals" who were similarly characterized by disease or origin of disability.

As significantly increased federal resources were made available during this era of the Great Society, initiated by John F. Kennedy and achieved by the Lyndon Johnson administration, the Department of Education, the Developmental Disabilities Administration, the Civil Rights Administration, and Mental Health and Alcoholism Institutes were created to right inequities and injustices.

Since the beginning of the State-Federal Vocational Rehabilitation Program in 1916, we have been aware that the client-counselor relationship was central to the vocational rehabilitation process. Begun in response to the needs of wounded war veterans, these processes were largely professionally driven. Most of the responsibility for decision making was assigned to the professional counselor's role. That relationship has been evolving from "allows" and more recently to "expects" the active participation of the person with a disability in the decision making.

Between 1916 and 1973, federal legislation established rehabilitation service models. The 1973 Rehabilitation Act introduced the Individualized Written Rehabilitation Plan (IWRP), which required that consumers and counselors **jointly** create plans for reaching rehabilitation goals (Rehab Brief, Empowerment Counseling, 1994). Severity of disability and specific eligibility tests became priorities with passage of the 1973 Rehabilitation Act.

It is in this period of history that vocational rehabilitation facilities (including sheltered workshops, day activity centers) came into their own. Significant infusions of federal dollars were provided for their construction, state-federal resources were earmarked for their utilization, and business and charities became involved in their sponsorship because it was considered good social and community responsibility. The need for trained and qualified rehabilitation professions was commonly promoted by government, providers, and advocates. We see, at this juncture, specific rehabilitation professions identified in rehabilitation legislation and federal dollars directed toward both their pre-professional (i.e., for staffing and student stipends for degree programs) and in-service training (i.e., funding for training individuals already working in specified rehabilitation roles).

Throughout the 1970s and early 1980s, vocational rehabilitation cherished its heyday of federal support because of the evident return on investment that could be traced to the rehabilitation of people with disabilities: Estimates were between 30:1 (Farrell, Knowlton, & Taylor, 1989) and 5:1 (Conley, 1969; Worrall, 1978; Hester & Decelles, 1991) showing recovered taxes on earnings for every federal and state dollar invested in a successful rehabilitation. No other social program could demonstrate such benefits to the nation's economy. Rehabilitation and special education programs were moved from "Welfare" to a new Department of Education. The Rehabilitation Services Administration was formed to coordinate and support a consistent state-level, professionally driven program. The National Institute on Disability and Rehabilitation Research was established as a functional unit in the Office of Special Education and Rehabilitation Services within the Department of Education.

At the same time, rehabilitation medicine came to be a fast growing medical discipline and the vocational rehabilitation professions and programs (counseling, evaluation, adjustment, placement) came into greatest acceptance. Accreditation efforts for rehabilitation service providers were established by the Commission on Accreditation of Rehabilitation Facilities.

Certification of qualified rehabilitation professionals was begun for the professions (i.e., rehabilitation counseling, then vocational evaluation). Resources to support the programs and to provide employment for disabled Americans came about at this same time such as the National Industries for the Severely Handicapped, which operated programs for purchase of products and services from rehabilitation facilities by federal and state governments. The balance of dollars between vocational-medical rehabilitation began its shift toward non-medical services, personnel development, and research and development.

Historic Foundations for Consumer Advocacy

The importance of public advocacy in shaping America's social and political fabric is a well established fact. It has its origins in the roots of America's social-political history:

- The principles underlying the U.S. Constitution were based upon the active promulgation of fundamental principles of human rights.

- Change from a confederation of states to a federal form of government (comprised of an executive, represented legislative, and judicial branches) came about because of a collective and vociferous recognition of the limits under a confederation.

- Economic and military actions promoted through law and international policy were driven by public conscience and beliefs in the value of democratic principles and individual rights.

- Formation of federal governmental agencies were promoted to assure that the commercial, defense, transportation, education, health, social service, and welfare needs of the country were equitably met.

- A strong federal presence was established between the 1930s and 1960s in the health, welfare, education, and social arenas because of inherent inequities experienced by significant numbers of Americans.

- The move toward decentralization of government and federally sponsored programs over the last two decades occurred because limitations in public systems have been identified by a more informed and active citizenry.

Influence of Advocacy on Rehabilitation

Today, we are finding advocacy a critical force in redevelopment of a national program for serving people with disabilities. We now realize that it is simply not a force only within a "concerned" professional sector. The lesson learned by today's advocates come from the achievements of political advocacy across the past several decades. What we are presently seeing in "consumer advocacy" is, in very real terms, a transfer of the techniques applied by public-advocates to the hands of persons with disabilities. It is likely that political advocacy will continue to play a significant role in forming and guiding national social programs.

The locus of authority for change has shifted. The format for achieving significant changes in the foundations of rehabilitation have occurred in a predictable fashion. An informed electorate (or an informed constituency) is better prepared to identify needs and potential options. Such an informed constituency is more able to express interest, propose alternatives based upon collective experiences, and aggressively pursue what they perceive to be more equitable approaches to solving the problems of disability.

With the 1986 Amendments to the Rehabilitation Act, we again saw important changes to the rehabilitation program coming about at the same time as changes in our social values and the impacts of political advocacy. These became predictors of how changes would be brought about through advocacy in the present decade. The source of advocacy efforts began to shift importance from single figures (e.g., the Mary Switzers), who wielded substantial power to influence Congress and federal agencies, to the collective power wielded through the hands of groups of individuals. This advocacy through collective efforts was built upon the power realized through the Civil Rights Movement, and it began to be wielded with greater importance in shaping broad national goals for rehabilitation:

- Vocational rehabilitation" was largely replaced in the language of the Act with rehabilitation";
- Independent living was identified as a distinct service option for people without immediate vocational goals;
- Supported employment was identified as a distinct program and outcome for the most severely disabled individuals;
- Underserved populations were identified as target populations for the federal-state rehabilitation program; and
- Requirements for need-based programming were introduced:
- A state plan must be formally prepared based on the assessed needs of persons in the state with disabilities,
    - Eligibility must be based on expressed needs among severely disabled persons,
    - An individualized rehabilitation plan must be developed based on individual needs, and
    - The state program must be evaluated based on the extent to which it meets needs of persons with severe disabilities.

These changes created the basis for the present emphasis for greater control over the individual's rehabilitation program into the hands of consumers of rehabilitation services. Throughout the state-federal levels of government, the influences of successive administrations began to play out the inevitable consequence of this civil rights achievement: Economic policy shifted from significant support for social programs to the creation of capital, industry, and

employment. Public policy shifted from strong federal control over programs to increased expectations of state and local governments and of individual-private initiatives to solve social problems.

Deregulation of federally created social, economic, welfare, and health programs took place. Appropriation levels authorized by Congress were reduced and, when allowable, the authority and funds for these programs were transferred downward through very broadly defined initiatives and social philosophies (e.g., supported employment). Finally, concerns over an escalating national deficit began to be reflected in the passage of more restricted budgets, in increasingly micro-level legislation, and by the oversight studies conducted through the Office of Management and Budgets and by Congress.

Federal agencies were reduced in their planning, monitoring, and compliance powers when authority was shifted to the state, local, and private sectors. Efforts to consolidate planning of the rehabilitation program at the federal level decreased as locus of control over its priorities and delivery changed hands. Democratization-decentralization challenged the basic tenets of a cohesive national policy and an integrated nationally supported coalition of rehabilitation programs and resources. Prevailing political attitudes predicted the need for "safety nets" as successive administrations moved to "neo-federalism" with its much more restricted view of government's social responsibility: A responsibility for meeting needs of only those persons unable to assure their own safety and well being; that is, the indigent poor, the most severely disabled.

Measures applied to judge quality of the programs were increasingly based on the dollars of similar benefits which the "invested" federal dollar leveraged through state, local, and private matching. Private contributions to charities (including to rehabilitation) and private sector commitments to employment of people with disabilities declined as corporate tax incentives disappeared and as the nation's industrial base began to shift from a hard industry base to an economy linked to technology, information, and personal services. Public dollars for rehabilitation shrank, were shifted to other programs, and moved downward to government units with goals based on regional priorities, of which rehabilitation would be one of many community concerns (e.g., competing for attention ~~and funding along with education~~, crime, unemployment).

However, with very real needs still present, a better informed electorate in place, a growing dissatisfaction with the difference between promise and delivery in government-sponsored programs, and an apparent loss of support for rehabilitation efforts, "collective advocacy" obtained a major injection of enthusiasm and support. Public activism and organized advocacy came of age. Collective advocacy spawned unique alliances between similarly concerned proponents of causes and at the same time seriously separated historically invested constituencies into separate camps (e.g., bureaucrats, providers, the professions). Collective advocacy took to shaping social and political attitudes around issues critical to groups of individuals affected by similar disabilities (e.g., parents of children and adults with developmental disabilities). Specific philosophies of quality of life and approaches to solving problems of disabilities became aggressively advocated and pursued as the "right alternatives" (that is, the socially responsible processes).

The combined force of this activism brought about passage of the Americans with Disabilities Act of 1990. The diverse and many voices of such activism significantly altered the substance of the Rehabilitation Act with the 1992 Amendments. In subsequent reauthorizations, we expect that direction and authority of the rehabilitation program will continue to shift, placing increasing control over the program in the hands of consumers, i.e., persons directly affected by disabilities. The demand for rehabilitation that meets "my needs" not only will be heard but will become integral to the design of the entire rehabilitation enterprise in the United States.

The monumentally important Americans with Disabilities Act (ADA) needs a vehicle through which its intended impacts on access to employment, housing, transportation, and public accommodations can be realized. The successful application of political advocacy which brought about passage of that ADA, demonstrated for collective advocacy, a strength that will neither be ignored nor diminished. Consumer advocacy is expected to continue to challenge the principles, processes, and priorities of rehabilitation services in the United States.

Basis for Increasing Consumer Choice and Requirements for Informed Decision Making

An important result of passage of the Americans with Disabilities Act of 1990 is that it furthered self-determination among consumers by presenting self-determination as an inherent right. The Act's greatest impact is expected to occur as it enables persons with disabilities to move from a point of segregation and dependence to a point of *integration and independence*.

> As a declaration of equality for persons with disabilities, the Americans with Disabilities Act (ADA) sends a clear directive to society regarding what its attitudes toward persons with disabilities should be: respect, inclusion, and support. The ADA is the result of two decades of effort, mainly by the disability-rights movement and its allies, to change policies based on quite different attitudes: pity, patronization and exclusion... (West, 1991)

Informed, responsible choice and advocacy are also consistent with the philosophy encompassed in the Individuals with Disabilities Education Act (IDEA) where the needs of the individual student are primary and where including students with disabilities in regular classrooms is a major goal.

At its philosophical basis is the Congressional finding that:

> ... disability is a natural part of the human experience and in no way diminishes the right of an individual to-
>
> (a) live independently;
> (b) enjoy self-determination;
> (c) make choices;
> (d) contribute to society;
> (e) pursue meaningful careers; and
> (f) enjoy full inclusion and integration in the economic, political, social, cultural, and educational mainstream of American society. (Rehabilitation Act as Amended in 1992, Section 2 (a) (2))

Once again, Congress provides the legislative vehicle for integration and independence. Persons with disabilities can link ADA with the Rehabilitation Amendments of 1992, two powerful weapons in their struggle for civil rights, independence, and integration. The Act further declares that "the goals of the Nation properly include the goals of providing individuals with the tools necessary to make informed choices and decisions." (Rehabilitation Act of 1973, as Amended in 1992, Section 2 (6) (a)).

The Act specifically requires the Secretary to promulgate regulations establishing criteria pertaining to the selection of the vocational rehabilitation services, and of vocational rehabilitation providers, by an individual with a disability, consistent with the individualized written rehabilitation plan under section 102. Regulations must include guidelines for assisting individuals with disabilities and for providing information about available vocational rehabilitation service providers.

Informed choice is afforded to eligible clients in relation to the setting in which the comprehensive assessment will take place. Section 102 (b) (1) (B) (iii) refers to the most individualized and integrated setting consistent with the informed choice of the individual. Section 102 (x) further requires as part of the Individualized Written Rehabilitation Plan that a statement must be included by the individual, in the words of the individual (or, if appropriate, in the words of a parent, a family member, a guardian, an advocate, or an authorized representative of the individual), describing how the individual was informed about and involved in choosing among alternative goals, objectives, services, entities providing such services, and methods used to provide or procure such services.

Informed choice, according to rehabilitation legislation, comes into play both during the comprehensive assessment and during development of the Individualized Written Rehabilitation Plan. The philosophy underlying informed choice (empowerment, self-determination, partnership, decision making), however, requires that the person with a disability actively participate at every stage of the rehabilitation process. It is the rehabilitation professional's task to ensure that informed choice is a reality throughout rehabilitation.

Subsequent reauthorizations of the Rehabilitation Act and operationalization of the Americans with Disabilities Act will be affected. Consumer choice, value for dollar invested, competition for dollars, measurable benefits to individuals with profound disabilities will more and more shape rehabilitation and special education programs. Simultaneously, dollars available for all social programs will continue to shrink and demands for "entitled" services increase among programs with funding.

Reasons for Significant Social Change and Demand for Rehabilitation Reform

There are important changes taking place in American society because of dissatisfaction and frustration over accessibility and quality of services needed by individuals with disabilities including medical, social, rehabilitation, education, public accommodations, and employment. New legislation and amendments to key rehabilitation legislation have now been achieved and

will affect how services are provided in all sectors of rehabilitation. These changes are expected to cause rehabilitation to better meet individual needs for economic self-sufficiency and community integration.

Rehabilitation programs exist to help address individual needs and to help individuals achieve real economic and community-based integration goals. In order to work effectively with the increasing diversity of individuals coming to rehabilitation programs, the program must be prepared to put innovative and established resources into the hands of practitioners and into the hands of the individuals the program was conceived to serve. With populations more likely to require life-long and intermittent rehabilitation resources, the program must be prepared to marshall existing resources (fiscal, employment, social, networks) and work with consumers and their individual support resources (e.g., family, co-workers).

The momentum behind and focus of people with disabilities derives from their dissatisfaction and general frustration with how society has met their disability needs and, more specifically, their sense that they could more meaningfully benefit from rehabilitation were they able to access resources when and how they need them. This momentum for changing how rehabilitation is conceived and delivered has been given added impetus because of the many general barriers individuals face that prevent them from achieving their economic self-sufficiency and community integration:

1. Social service agencies that were designed for maintenance and caretaking, rather than for rehabilitation and personal achievement;

2. Public service organizations that provide minimum quality responses to disability need, even for those who are most aggressive in demanding their rights;

3. Community resources that can rarely be accessed because of geographic isolation, limited or inaccessible transportation, physical and architectural barriers, and technological biases that promote a limited range of alternatives and human choices; and

4. Jobs and careers that are closed to people with disabilities because of social, employer, and co-worker reluctance.

The Americans with Disabilities Act of 1990 and the 1992 Amendments to the Rehabilitation Act are intended to help reduce many of these barriers. The Americans with Disabilities Act was passed because of the momentum for social change and the power of advocacy and disability coalitions. That Act was conceived with the hopes of removing the kinds of barriers described above. The Act is expected to be especially valuable in increasing access to employment and access to public services. The considerable testimony presented during hearings for those legislations made quite clear the civil rights nature of concerns and the strength of consumer voice in shaping legislation. That same voice is now enjoined to achieve changes (or reform) in how the state-federal rehabilitation program is designed and delivered.

Trends Contributing to Rehabilitation Reform

The confluence of the following broad social and rehabilitation specific trends (along with others) will dramatically change rehabilitation. Rehabilitation will continue to be faced with very fundamental redefinition and restructuring of state agencies; the roles of professionals and consumers; its central mission and function in the arena of disability; and how resources are acquired, coordinated, and equitably applied.

Broad Social Trends. General trends such as the following will have a significant impact on rehabilitation in the next century:

1. Industries are reducing work force size, global competition is causing transfer of some jobs to other countries, improved technology is eliminating others, and many of the new jobs being created are part-time or temporary positions with low wages and few or no benefits (Geneal Accounting Office, 1993, American Rehabilitation Association, 1994).

2. By the end of the century, about a quarter of all workers entering the American labor force will be immigrants (Federal Immigration and Naturalization Services, 1987, in Reich, 1991, p. 216).

3. Each year the ranks of the illiterate swell with one million teenage dropouts and about 1.3 million non-English speaking immigrants (Naisbitt & Aburdene, 1985, p. 152).

4. Fifteen million individuals are receiving welfare benefits and more than half of the individuals on welfare rolls are long-term recipients.

5. Seventy-two million Americans have experienced a serious injury, stroke, or other disabling disease; 35 million Americans have ongoing disabling conditions; and more than 9 million are unable to work, participate in education, or live independently (1994 Harris Survey).

6. Work disabilities increase with age such that 22 percent of disabilities for persons 55 to 64 years of age are work disabled (1994 Harris Survey).

7. Two-thirds of working age Americans with disabilities are unemployed, while 20 percent are working full-time and 11 percent are working part-time (1994 Harris Survey).

8. Eighty percent of unemployed working age adults with disabilities would prefer to work (1994 Harris Survey).

9. Twenty-five percent of adults with disabilities have not completed high school (1994 Harris Survey).

Specific Trends Affecting Rehabilitation. Rehabilitation today is already undergoing

significant changes as indicated by the following trends and events:

1. Organized and visibly effective disability rights movement aligned to goals of family members and individuals with disabilities who are disenchanted, dissatisfied, and disenfranchised by government, education, public institutions, and the helping professions (i.e., medicine, social work, rehabilitation).

2. Increased emphasis on full integration and inclusion of all persons with disability needs.

3. Struggles to implement (and litigate under) the employment, civil, technological, and access provisions of the Americans With Disabilities Act of 1990.

4. Expanded applications of "supported and naturalized" concepts and programs to employment, independent living, residential options, education, and access to public resources.

5. Increasingly targeted expectations for all federally authorized efforts to focus on severity of disability and diversity through the 1992 Amendments to the Rehabilitation Act.

6. Greater expectancy to pursue career development and life-long benefits over immediate job placement or restoration outcomes.

7. Increased demand that more services and related resources be community-based and within reach and control of individuals and families involved with disability.

8. Recognition that needs of persons with disabilities may originate in such social problems as poverty and drug abuse, that some significant needs are low incidence, and that needs can mitigate or are exaggerated due to cultural and society's influences.

9. Expanded avenues of opportunity provided for rehabilitation through technological innovations: biological, computer, pharmacological, and mechanical.

10. Continuing public dissatisfaction with the equity, costs, and quality of social-welfare-health care provided under the aegis of governmental, public, and non-profit agencies.

Consequent Expectations for the Rehabilitation Program. The most important impact on rehabilitation in the next decade is a new way of thinking about how, where, and with whom people with severe disabilities can (or should have the opportunity) to live, to learn, to work, and to play. This new way of thinking will alter historic emphasis on preparation, restoration, care, and treatment of people with disabilities to a concentration on supporting participation, building on capabilities, adapting environments for building relationships with individuals with disabilities, and designing new service directions with them.

The old way of thinking offered individuals (and rarely families) a limited number of options. The new way of thinking means assisting individuals and families in identifying what is important to them and helping to empower them with decision-making and spending authority to act upon those choices. These new perspectives about what rehabilitation should be are suggested by the expectations that consumers and other sectors of American society are coming to expect of rehabilitation and other social programs:

1. Base service provision upon expectations and informed choices, strength and needs of individuals and their families, rather than forcing choices from among a narrow range of preset options and approaches.

2. Plan and provide services based on what people need and their abilities, rather than providing more services than are needed or not providing those services that are needed.

3. Increase service quality, rather than expand program capacity.

4. Seek service arrays that allow differential access and alternative mechanisms for assistance and support, rather than providing a service continuum that relies upon special facilities and programs.

5. Move from grouping separate and independent services to recognition of a need for a holistic, interdependent, and integrated service system to meet the employment and life needs of different disability groups.

6. Move toward a delivery system where it is possible to create individual support utilizing any resource available within the community.

7. Move toward a service payment approach based on vendor performance in relation to individual needs.

8. Increase expectations and demand more of the individual, their families, and service providers.

9. Shift to life-long functional planning based upon individual consumer needs for rehabilitation and self-management.

10. Encourage the individual, family, and community members to gain access to the resources available in the community (e.g., job; living arrangements; relationships with family, friends, and associates), rather than replacing those resources with places populated only by professionals and other persons with disabilities.

11. Coordinate services and supports around the life of the individual rather than around conventional staffing models or traditional services-delivery designs and operations.

12. Use ordinary citizens (i.e., children, co-workers, neighbors) to teach people skills, assist them to participate and contribute and serve as models of appropriate

behaviors and the development of interpersonal relationships.

13. Promote habilitation and rehabilitation as natural community processes, rather than isolating experiences into which an individual is put until the process in complete.

Demand for and Reform in Rehabilitation

> I would suggest that the challenge facing providers of vocational rehabilitation services ... involves (a) the need to create a social consensus regarding the value and purpose of rehabilitation within the community as a whole; (b) the need to create programs and services which value consumer choice while aggressively managing and utilizing scarce resources; (c) the need to improve and expand accountability; (d) the need to actively promote and develop linkages with a broad array of community resources, programs and services not necessarily 'identified' with disability issues; and (e) the need to aggressively resist the tendency to eliminate or otherwise ignore the needs of special populations as social agendas are established and implemented. (McKenna, 1994, p. 5)

The demand for reform in social programs (including rehabilitation) is in large part a reflection of changes taking place throughout government and America that will naturally affect what it is that we will need to be about in rehabilitation. It reflects the range of issues dealing with relevance and responsibility as viewed through the eyes and expectations of the constituencies of our various national and regional programs. This call for reform is about the relevance of social, medical, and rehabilitation programs in relation to who are appropriate and informed recipients and who has rightful claims upon America's various systems and resources. The call for reform can be summarized in three credos:

> **Inclusion**, by designs which permit broadest applications to individuals with rehabilitation needs, regardless of their locale, cultural heritage, or composition of their disability.
>
> **Access**, for individuals in forms that are appropriate to need; are readily available, and affordable;
>
> **Impact**, on outcomes which are measurable, relevant, and valued by individuals with disability and society in general. (Menz, 1994)

Rehabilitation is at a crossroad, faced with tremendous opportunity to provide direction for persons and organizations concerned with the impacts and resolution of conditions brought about because of physical, psychological, and functional impairments. Rehabilitation has been an important resource for empowerment of persons with disabilities in our society through public resources and professional and consumer integration. To remain such an important resource, we must find partners throughout the consumer and professional communities with whom to work for clearer and appropriate expectations of rehabilitation and we need to engage in self-examination and personal exploration of the conflicting demands that shift in methodological paradigms have required of us.

The broad goals of rehabilitation may remain unchanged. The methodologies, strategies, and possibilities of rehabilitation though will continue to expand. The scope of rehabilitation services will extend over the next decade to include new technologies serving new populations, serving individuals with a greater severity of disability, and providing individualized services based on informed consumer choice without a commensurate expansion in resources. Rehabilitation professionals (i.e., rehabilitation counselors) have seen themselves in the role of "helping," and it may be difficult for them to perceive that the consumer will be the one to whom they will have to be primarily accountable.

The spirit and enforcement provisions in the newer civil rights foci do not permit a status condition but, rather, further compel a climate rich for change. Those emanating actions and regulations are today widening what can and will be real within America and among Americans with disabilities from within and across all segments of a diversified American culture. An important role which agency counselors and consumers can share is that of determining the alternatives.

Rehabilitation will continue to experience unprecedented changes during the course of the next decade. New rehabilitation models will make it possible to meet the needs of individuals consistent with current philosophies of rehabilitation. Information technology has helped foster many of the changes. Increased access to knowledge via technology will assist all service providers to have equal access to, and full participation in... but, what about consumers and their access and equal participation?

> We must begin now, with what we have, because what we will need has yet to be revealed or fully charted. The first steps should be to build the infrastructure of communication with all members of the rehabilitation community, openly talk about this new frontier, and define the future as we encounter it. Visioning is not an event--it is a process [that needs to] ... regularly [occur] at all levels of rehabilitation ... through collaboration. We must "unite our vision" through true collaboration with all stakeholders at all levels to build a rehabilitation ... "system" that is flexible, responsive, and accountable to its customers and produces quality employment and independent living outcomes for individuals with disabilities. With less structure and more shared leadership, less revolution and more resolution, less turfism and more true collaboration, rehabilitation ... will move with vigor into the 21st century.
>
> The unsettling thing about new paradigms is the process of re-definition, when power structures change and roles are re-defined. For full development of the new paradigm to occur, we must open to scrutiny the very things which may have been held in sacred trust. We must neither obstinately hold to the old forms, nor thoughtlessly discard them without demonstrated cause. Instead, we must openly explore their validity, relevance and impact to the new directions of rehabilitation as it enters the 21st century. (McAlees, 1994, p. 22)

The need to resolve disability and diversity problems and design rehabilitation practices and resources consistent with needs of people with disability in America's population is imperative, and we must promote increased collaboration among consumers, practitioners, and

others where each partner recognizes the other's complementary capacities. "Partnering" or "collaboration" connotes working directly from the strengths and differences that the partners have to offer, an open relationship based upon what their combined capacities might yield and upon the integrity and commitment of the partners to achieve valid outcomes. The combined expertise and experience should yield processes that are much more broadly conceived and more relevant to fundamental disability and rehabilitation issues.

Responding to the Call for Reform

Informed decision making is an added requirement for rehabilitation practice (in all sectors of rehabilitation), and it is a compelling reason to return to the foundations of rehabilitation practice. Working with and on behalf of an individual's needs has always been central to rehabilitation, regardless of any professional penchant to "do rehabilitation on them." Perhaps more importantly, the demand for "informed choice and full involvement" presents a fundamental resource for achieving the reformed rehabilitation program that people with disabilities and American society are calling for throughout all of our social, educational, welfare, and medical institutions. Altering the system from within may be the more telling reason to pursue full inclusion and full self-determination in the rehabilitation process. Perhaps the seeds for change will arrive from how the practice-level roles and capacities develop between "professionals" and "consumers."

> Re-envisioning of the national rehabilitation program leads us to propose it as a confederation in which the unique efforts of organizations, associations, professions, and public agencies are integrated toward disability issues and rehabilitation needs. Public funding would support a system which enables collaboration among the resources in the public and private domain to meet rehabilitation and disability needs issues at the national level. The program would continue to support three purposes: collaboration between relevant constituencies, provision of quality services, and assurances of necessary resources. (Menz, Evenson, Griswold, & Verville, 1994, p. 8)

If we can anticipate at least the general characteristics of a "re-envisioned" rehabilitation program, we will be much more credible to individuals with disabilities and rehabilitation disciplines when we suggest changes. In some cases, radical and sweeping changes may be needed to achieve our preferred vision of rehabilitation delivery. Planning an appropriate system for persons with disabilities must consider preferred outcomes for a rehabilitation program (i.e., employment, integration, self-determination) and requires that we face up to the issues for whom the program can be most effective. Further, planning must become consciously critical of where, how, and whether our preferred outcomes can be achieved with present resources.

Rehabilitation's Capacity for Reform

> As we further shape a ... better national program, we must evaluate what the real costs will be in doing so in terms of both human capital and social resources. Above all, what we design must contribute to the empowerment of both providers and of consumers of vocational rehabilitation services in ways that can ensure accomplishment of the vocational and independent living goals of America's

individuals with disabilities. (Menz, Evenson, Griswold, & Verville, 1994, p. 3)

What Rehabilitation Does. Rehabilitation has developed characteristics over the decades that make it able to positively respond to pressures calling for reform in rehabilitation:

- Rehabilitation serves needs that arise due to the presence of one or more disabilities.
- Rehabilitation focuses upon the individual and his/her rehabilitation needs relative to disability.
- Rehabilitation comprises an established body of knowledge, practice, and technology (medical, vocational, social-psychological, electro-mechanical).
- It is likely that political advocacy will continue to play a significant role in forming and guiding national social programs. Rehabilitation has successfully infused its principles and values throughout medical and social-psychological disciplines and practices.
- Rehabilitation is a transdisciplinary collection of practices that can be applied to the refinement, enhancement, and the amelioration of conditions arising from disability.
- Rehabilitation has become mature as a professional body of knowledge, that is applicable through many disciplines, though that body of knowledge needs to continue to mature.
- Rehabilitation is comprised of multiple disciplines, each of which contributes singly or in combination to an individual's achievements well beyond the period of time in which formal rehabilitation processes have taken place.

Rehabilitation's underlying philosophy stresses that rehabilitation serves individuals, first of all, who are confronting problems or conditions arising from disability. Its values require that rehabilitation is applied on an individual basis. It has evolved as a profession characterized by a philosophy that values the whole person, a comprehensive process that guides disparate endeavors of persons with different skills, a body of competencies for many of its professional groups. Rehabilitation has legislative and social mandates; has standards for ethical practice; and is fully engaged in a continuing debate over what constitutes appropriate goals, practices, and responsibilities of its members.

What Rehabilitation Achieves. Rehabilitation is now professionally based and integrates the multidisciplinary foundations upon which it was established and upon which it continues to rely. As a multidisciplinary profession, its members are committed to eliminating barriers to social and economic opportunities experienced by individuals affected by disability. Achievement of rehabilitation outcomes with individuals are accomplished through the separate and combined practices of those disciplines.

Barriers may have multiple origins: individual, personal, environmental, societal, attitudinal, economic, legal, or functional in origin. Needs occur when such barriers or

limitations arise in association with disability and prevent an individual (or a group of persons) from participating successfully in some preferred enterprise (e.g., employment, use of public transportation, recreation, home ownership). Barriers need to be addressed through the individual, through a specific environment, or through society more generally. Consequently, the elimination of barriers may require changing, redirecting, or applying technology to the individual or on behalf of the individual to the environment or through society. The specific rehabilitation practices used to eliminate barriers may be drawn from professional practices in medicine, physical sciences, engineering, vocational rehabilitation, psychology, law, and other disciplines that might be required.

Values Basic to Rehabilitation. Its members work with individuals to address barriers to their economic and social participation under a set of values including the following:

1. Respect for individual dignity;

2. Appreciation of individual differences, needs, and goals;

3. Expectations of self-determination and of personal responsibility in rehabilitation;

4. Commitment to individual rehabilitation goals, productive and full participation in society;

5. Recognition of the contributions to potential aids that technology and other social accommodations will make for persons with disability;

6. Belief in possibility and the role of abilities regardless of severity; and

7. Belief in and commitment to human and professional ingenuity.

Rehabilitation Principles. Principles are translations of core values of rehabilitation: Basic valuing of individuals and their rights to self-determination, the variety of individuals and resources that may be instrumental in rehabilitation, orientation of services to customers and their rehabilitation needs through rehabilitation practices, pre-eminence of the consumer's goal attainment, and uniqueness of the rehabilitation endeavor in its application of public resources to achieving benefits that are societally valued as well.

1. Rehabilitation occurs as a result of the application of valid practices and application of skills brought to bear from many disciplines, as needed, and depending on how disability has affected the life of an individual. The disciplines include medical, social, vocational, and psychological specialties and focus on diagnosis, counseling, planning, guidance, intervention and treatment, support, and follow-along.

2. Rehabilitation is about serving individuals and their needs for rehabilitation arising from disability. Those individuals include the person whose life has been directly affected by an impairment and individuals within that person's community-of-influence who deal with the consequences of disability (e.g., family, co-workers) for the individual or are in position to alter the impact of disability (e.g., employer,

social service agent).

3. Rehabilitation is about aiding individuals to satisfy their goals and aspirations that may be thwarted or somehow limited by disability; whether those limits derive from impairments, barriers present in society as we now configure it, limits in our knowledge of technological applications, or failures of ingenuity and invention.

4. Rehabilitation is above all else a human endeavor on behalf of individuals who are not benefiting fully within the social and economic parameters of American society.

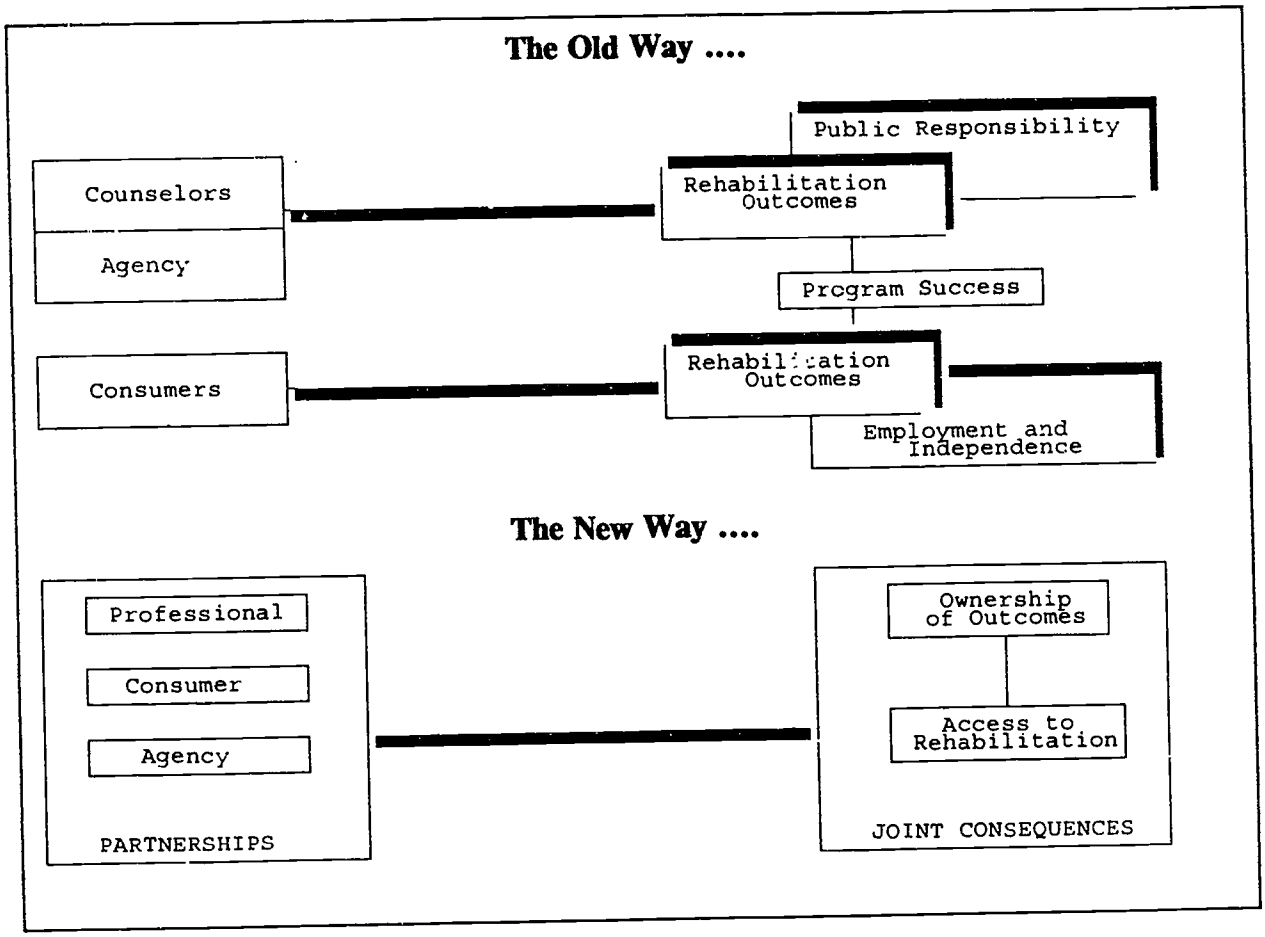
5. A fundamental value (and perhaps a reason for its success) is rehabilitation's emphasis and focusing of its resources around the individual's unique needs for rehabilitation and their potential to benefit from rehabilitation.

Changing From the Old to the New

The time is right. The conditions are supportive. The rehabilitation program has the capacity to try a new way. The display on the next page summarizes what the old way is perceived to have been and suggests the kind of change that seems to be required with the new way. Under the old, there was the perception (if not reality) that the "system" and the "consumer" were on parallel courses pursuing seemingly similar types of goals. Too often, though, the goals of consumers and the system, while similar, had different values. For the public, the system was successful when the program's clients achieved publicly acceptable outcomes, while it would be successful to the clients when it served them well and they achieved their personal goals. Only when both the consumer and the public equally prized an outcome (i.e., employment or community integration) could the system be judged as appropriate by both the public and consumers.

The new way requires us to create an atmosphere which recognizes the interdependence and strengths achieved through the perspectives of the three central partners in rehabilitation: the rehabilitation professional, the consumer, and the support that can be available to them through the rehabilitation agency. Concern is not about who controls resources under the new way as all three bring unique resources to this partnering process. Instead, the concern is to assure the presence of a process that brings about outcomes and benefits that are owned by the individuals and created via respect and interdependent application of the unique resources of each of the parties.

What is being called for is to re-establish our perceptions and practices (in some cases) in keeping with the values and principles adhered to by rehabilitation professionals. The values discussed above are in keeping with what consumers are demanding. The principles and professional skills and behaviors *applied* to people with rehabilitation needs are also in large part appropriate. The changes required of us are in our approach, our application, and how we go about achieving balance between which of the partner's resources are most important - or viewed as most important.



Old and New Ways in Rehabilitation

It is proposed that a partnership be built upon informed choice to enable consumers to develop their decision-making skills and their capacities to make choices that yield outcomes of essential benefit to consumers, as well as in keeping with society's expectations for the program. As depicted in the above figure, the partners are going in a consistent, common direction and together under this model. It is hoped that our attention will move from an almost exclusive concern with equity among the partners within the process and focus on how the process can yield joint consequences, ownership, and valuation of rehabilitation and consumer goals; that is, we will find ourselves jointly pursuing the same outcomes and find increasing transfer of ownership of outcomes from the rehabilitation professional to the individual consumer.

Popular Erroneous Perceptions of Vocational Rehabilitation

There are many popular and erroneous perceptions held by the public and our potential partners in rehabilitation that we need to change. Among these perceptions (some of which may be accurate in some agencies) that detract from the programs achievements are the following:

1. That the rehabilitation program is not for high functioning people.

2. That the vast majority of highly capable, dedicated, and empathetic vocational rehabilitation counselors must routinely stretch the system to accommodate individual needs and career dreams.

3. That consumer interests and needs can be determined with the consumer and need not take a great deal of time. They can be identified in a couple of interviews.

4. That at the wages consumers will get if they become employed, they will lose medical, Social Security, and county support benefits that may be essential to their continuing to work.

5. That consumers applying to rehabilitation are treated based upon a diagnostic label, and choice is permitted when their competence to make realistic decisions is confirmed under that diagnostic profile.

6. That rehabilitation counselors, these days, are likely to place people in jobs that no one else wants - convenient, entry-level, dead-end niches, instead of identifying career ladders that are personally meaningful to the consumers themselves.

7. That people who acquire disabilities during their career will be told "You are going to have to lower your sights." It is easy to call "unrealistic" their desires to use their still functioning skills, abilities, and often extraordinary talents.

8. That consumers cannot re-enter the rehabilitation system if their career goals change or they have needs related to career advancement. They need to know that they may rapidly begin to feel empowered and get in touch with the long-term career ladders they really want to climb.

9. That informed choice will make the system work faster.

10. That consumers should not seek training to become consumer-professional role models in vocational rehabilitation.

11. That believing a disability entitles consumers to whatever they want. Services have a better chance of being effective if both counselors and consumers agree on how needs may best be met.

12. That counselors have only test results to go by in making choices. Consumers must be encouraged to identify and express their individual needs, values, and dreams--and have these respected and incorporated in their rehabilitation.

13. That consumers cannot problem solve creatively, evaluate options, or achieve resolved decisions; educate themselves about skills needed and the "realistic" nature of potential goals; develop short and long-term career plans; become self-empowered self-advocates; develop their own substantial rationale and plans for realistic career choices; or learn life and job skills needed for job-keeping and career advancement.

14. That rehabilitation does not take into account an consumers' self-assessment of their likes and dislikes, strengths, or resources; what they are good at or enjoy doing; their priorities, concerns, and ways to expand self-assessment through community providers; their career dreams; how to develop, maximize, or optimize options based upon pros and cons; or help consumers clarify values or reframe experiences of disability as strengths or sources of new long-term meaning and career goals.

15. That career counseling, peer support group, and rehabilitation are equally effective. Peer support and career counseling, however, are more consumer friendly (or consumer-oriented).

16. That consumers under the traditional way rehabilitation is done are not likely to get what they need or get benefits that are important to them and are likely to be treated in a demeaning fashion.

17. That the vocational rehabilitation system is not capable of reconciling the need to account for public funds with the need to be flexible and innovative in arranging consumer-responsive services and supports.

18. That it is easy for people with disabilities to see no hope for improvement in the future, to become depressed, to relapse or quit jobs in despair, and to return to the system for yet another hopeless, depressing, "realistic" entry-level placement.

19. That informed consumer decision making will make rehabilitation more time consuming, require more difficult work on the part of the counselor, will denigrate the professional identify and skills of rehabilitation counselors, and will interfere with individual rehabilitations.

20. That if counselors have to explain in detail alternatives for preliminary assessments, eligibility determinations will be delayed and become burdensome.

21. That both control and responsibility over rehabilitation are transferred from the counselor to consumers. Counselors can no longer say "no" to consumers' choices or demands.

22. That informed choice is revolutionary to most health and rehabilitation professionals and perhaps even in contradiction to their training and long-held concepts of best practices. The consumer's ability to choose has not been a rehabilitation goal, nor has the need for training of consumers to develop competency in making informed choices been part of rehabilitation practice.

23. That informed consumer choice is a threat to both counselors and the state rehabilitation agency.

24. That rehabilitation will continue to be provided as it always has been by the counselor to a consumer who is a willing recipient of a plan for services that are appropriate for him/her.

25. That consumers face the luck of the draw in getting interpersonally grudging or generous counselors who will give them the benefit of the doubt.

26. That state rehabilitation agencies can develop lists of providers available for purchase of services, and consumers then can be responsible to work with these resources to achieve their desired rehabilitation services.

27. That consumers often return to the vocational rehabilitation system in a revolving door pattern that is disheartening to counselors and consumers alike. People with severe disabilities rarely become independent on Social Security and medical supports, are working at levels far below their abilities and skills, and are unable to retain or advance in employment.

28. That the vocational rehabilitation system was designed to meet the needs of white, middle-class people. Counselors need to be trained to reach unserved and underserved populations, specifically with respect to planning, outreach procedures, culturally sensitive counseling skills, and culture-specific behaviors that may influence what might be included in "informed decision making."

29. That consumers' rights to self-determination and informed choice are new in rehabilitation coming about with the 1992 Amendments to the Rehabilitation Act.
30. That consumers are entitled to choose where their needs will be met, regardless of the cost. They have the right to an open checkbook entitlement (e.g., send a consumer to a prestige college even when a local college offers comparable training).

31. That the rehabilitation counselor is the "one-up expert" who evaluates, assesses, and knows everything. The consumer is the "one-down recipient" of test results and the counselor's wisdom.

32. That test findings determine what choices are "realistic" and results in "giving consumers what the assessment says they need, not what the consumer wants."

Preferences and/or Realities That may be Accomplished Through Consumer Choice and Informed Decision Making

We are trying to change these 32 perceptions listed above about what rehabilitation is and what informed choice will enable or how it may affect the rehabilitation process. Were the new way effectively pursued, the following changes in preferences, perceptions, or realities may be accomplished:

1. That consumer career choices will be the threads to pull through the rehabilitation process, with skills taught as needed and devised around a career ladder model that leads to employment, job retention and promotion, and consumer's own quality of life goals.

2. That the majority of counselors will be flexible and positive, and willing to accept

consumer choice and the challenges brought about by choice, and willing to "bend" program regulations to genuinely address individual needs and dreams.

3. That counselors will teach skill building to consumers and families. Skills should be taught in an applied manner, not in a vacuum or through a lecture that might confuse the consumer. Counselors should use this opportunity to empower consumers to choose immediate placements and to choose future jobs on the bottom rung of the right career ladder.

4. That everyone can and will have a career goal by the time they leave rehabilitation.

5. That meaningful choice also means increasing opportunities for consumers to make meaningful and informed decisions about services and supports needed, and how and by whom they are provided.

6. That family members, guardians, and other advocates are encouraged to help consumers to not settle for safer, easier, lesser outcomes.

7. That meaningful and informed choice means consumer choice, with adequate information on the consumer's identified strengths, resources, priorities, concerns, abilities and capabilities, and also on the consumer's personally meaningful short-term employment goals and long-term career and quality-of-life goals.

8. That consumers will increasingly become full, equal partners in the process of their own rehabilitation programs. Counselors need to encourage this transition by moving from primary roles as evaluators, decision-makers or money-managers, to being freed to use their guidance and counseling training, skills, and professional expertise as advisors, consultants, and advocates.

9. That the goal of the rehabilitation process will be to provide individuals with disabilities the tools and adequate information necessary to make informed choices and decisions leading to achievement of personal employment and quality-of-life goals.

10. That a key issue in consumer choice is "What is reasonable?" If costs in staff time and resources are low, placement results are low and consumers recycle through the system. There is a relationship between consumer choice, cost benefits, and consumer long-term quality-of-life satisfaction.

11. That available funding and staff will be stretched to serve increased numbers of people with severe disabilities who need increasingly costly and time-consuming services.

12. That a basic career counseling philosophy will be recognized: that the process of choosing should be done by the consumer and that not all decision making will take place as consumer and counselor are meeting. Decision making ultimately takes place through the consumer's own process, not through a counselor's assessment.

13. That like most people, consumers stigmatize others with a disability--including stigmatizing themselves.

14. That state agencies face realistic problems with state government mandates, policies, purchasing requirements, and regulations and that changes may be needed in the rules that agencies operate under.

15. That counselors retain responsibility as professionals to present their best judgments, provide fair hearings, be non-prejudicial, contrast expert-based information, and say no when alternatives are not permissible under program regulations. Counselors must inform consumers that they have the right to appeal, since counselors, too, may be mistaken. Consumer challenges, appeals for arbitration, and litigation on these approaches are expected as part of the process.

16. That it is important to recognize that career and life planning are processes that take time, especially for people who have encountered disruptive life experiences.

17. That along with consumer choice comes consumer responsibility to test and implement choices. The counselor may help the consumer to research options, explore what is possible and feasible, test reality, and bring back a convincing case to the counselor --and win! Or, the consumer may learn independently that the plan is not realistic and abandon it. Or, if the plan is questionable, it may still be chosen by the consumer who may then rely on trial and error.

18. That every individual's situation is unique and each requires mutual discussion and flexibility to create solutions. While the consumer may choose a vocational goal that may go in direct opposition to a comprehensive assessment, the counselor retains the right or responsibility to say "No."

19. That consumers retain rights to challenge eligibility decisions and service needs determinations.

20. That a key to ending the revolving door syndrome lies in increased consumer career choice and higher quality placements, which can lead to realizing longer term career plans.

21. That consumers obtain validation for being upset about having lost a career and having their life altered by disability.

22. That counselors keep open minds, give consumers the benefit of the doubt, help create hope, and encourage consumers to expand their visions of what is possible in life-long careers.

23. That informed consumer choice may take more time, but not a great deal more than counselors spend with confused consumers struggling against what may feel to them like a juggernaut system. And, it may take less time if counselors do not assume full responsibility for everything that happens, but shift responsibility, as well as

rights, to consumers and others involved with consumers.

24. That counselors emphasize a new style of relating to consumers to facilitate rehabilitation: Counselors need to learn how to empower consumers by accepting consumers as partners rather than as clients; by showing consumers respect and confidence in the consumer's capabilities; by emphasizing strengths and building capacities; and by showing a willingness to share resources and opportunities.

25. That in implementing consumer self-direction goals, it is important to recognize, validate, and help diminish the realistic barriers, the sense of threat, the baggage of fears, and the attitude and behavior changes inherent in learning to become consumer oriented.

26. That rehabilitation counselors understand that returning to a career is a process of regaining hope. They know that for some consumers a few months in a transitional entry position may be very helpful in getting back into the swing of working. They may quietly extend the standard two-month follow-up of closure.

27. That consumers want increased control in rehabilitation over choices and processes that directly concern them and strongly affect their life quality outcomes.

28. That the system may prove more cost-effective in both time and resources when consumers get on the right career ladder in the first place and do not recycle through the system.

Changing Perceptions

The truth of the above perceptions (or, myth and lore) depicts the adversity that presently exists, reflects confusion over what the rehabilitation program is becoming, and relates misinformation of what the rehabilitation program does with and on behalf of consumers. The preferences or potential realities listed above suggest some of the more positive benefits from increased consumer choice and informed decision making. In the following two sections, we will help you to see how consumer choice can become very much a part of how rehabilitation is experienced by consumers and to see how consumers, the program, and society may benefit by clarifying how informed consumer choice can become viable and integral to rehabilitation practice.

Chapter III

Roles and Responsibilities in the Informed-Choice Process

Introduction

So far we've looked at what informed choice is and the issues facing us today as we make the change (Chapter I) as well as the historical and legislative evolution that lead up to the change (Chapter II). Given that backdrop of "what" and "why," it is now time to look at the role and responsibilities of the primary parties in the informed choice process. Just knowing about informed choice isn't enough to make it happen. Unless responsibilities are identified and defined, the concept of informed choice will remain just that, a concept. This chapter then is the "who" chapter. It begins to add substance to the concept of informed choice and prepares the reader for Chapter IV, the "how-to" chapter. These two chapters take the concept and give it life. They will outline practical applications that can be used on a daily basis.

The principal parties in the informed choice process are the consumer, the counselor, the agency management and, collectively, other community programs. These roles are not mutually exclusive; rather, all players have a shared responsibility in the informed-choice process. It's not just a consumer responsibility to make the informed choice process work, nor is it just the counselor's, nor agency management's, nor someone else's in the community. Informed choice will work only if all parties understand the concept, mutually respect one another, and accept responsibility for making it work. It needs to be accepted by all partners as the way to do business if the informed-choice process is truly to become a reality.

For purposes of precision and clarity, the roles and responsibilities of each partner-counselor, consumer, agency management, and other community programs - are addressed separately in this chapter. But keep in mind it takes *all* partners consistently working together and in concert for the full effect of the informed choice process to be realized.

Role and Responsibilities

Counselor

It is a basic principle that if you desire satisfied customers, you must first understand what the customer's expectations are. Once you understand these, you can then focus your services and service delivery methodologies in such a way as to ensure a satisfied customer outcome. Customers of the vocational rehabilitation program are no different. If counselors are not sensitive to what consumers expect from them, the informed-choice process may in reality be a forced (artificial or rote) process without real personal meaning for the consumer. Thus, when counselors are developing partnership relationships with consumers, they must consider

Consumer Informed Choice
- The Partners and Their Relationship -

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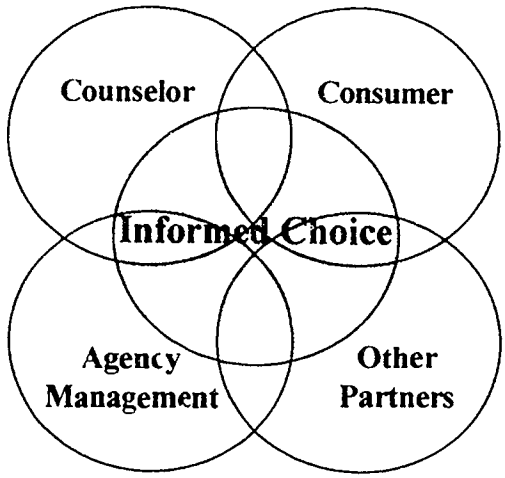

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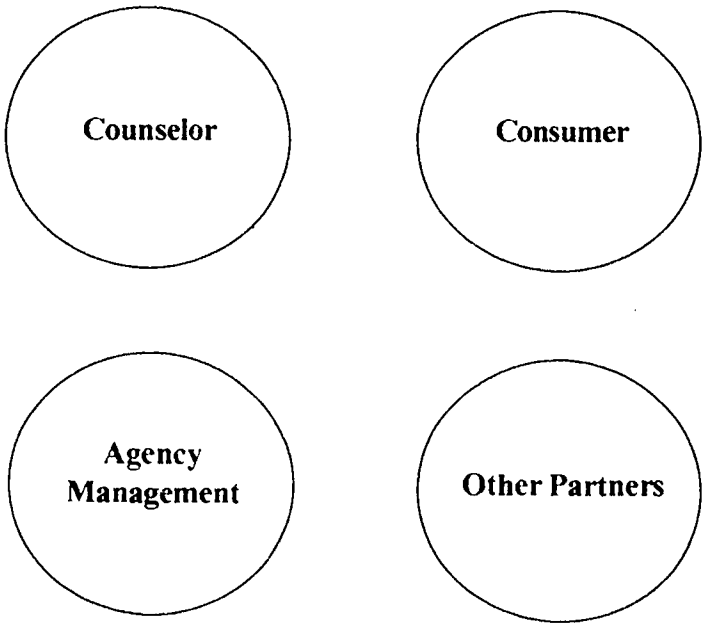


what the consumers expect of them. Understanding expectations serves as the foundation upon which the trust implicit in the informed choice process is built.

What does a consumer look for in a counselor? What are the consumer's expectations? How does the consumer hope to educate the counselor regarding expectations and goals? Different consumers will have different answers, but they share some things in common. A basic expectation of consumers is that the counselor's behavior reflects an *attitude of respect* for the consumer and that the counselor focuses on the individual, not the disability. The experience of being valued and affirmed can be energizing. This attitude is also reflected when the counselor respects the consumer's responsibility to make the final informed choices and decisions in his/her rehabilitation.

Consumers hope for an *attitude of realistic optimism*, with the counselor focusing on strengths, not deficits. Consumers want to be recognized for their areas of potential and what they have going for them, not their liabilities.

Consumers expect to be heard and understood. The counselor's *listening skills* are, therefore, basic to the partnership and this means hearing not only what is said but also what is meant. Consumers enter the relationship with ideas, hopes, and aspirations, and if they feel these are not heard or respected, then they may quickly give up.

Consumers hope to find in their counselor an *advocate and a partner*, someone who's on their side. Their hope for vocational rehabilitation is to be able to work together with the counselor and receive support in reaching their goals.

The consumer expects the counselor to be a *resource* and to have the information and skills that promote goal achievement. Resource needs vary with each consumer. Some consumers see the counselor as a source for money to finance their rehabilitation, while others may need the counselor's knowledge regarding resource providers such as training programs and equipment. Others want ideas about technology and medical solutions. Still others may want their counselor to be a problem solver and to take responsibility for the consumer's rehabilitation (indicating a need for empowerment skill development). Consumers expect an environment in which they feel free to openly and clearly communicate their needs to their counselors.

Finally, the consumer expects to find a person of *integrity* in their counselor. They expect openness and honesty, which means someone who is straight forward in his/her thinking and behavior. They expect to be able to trust their counselor.

When these expectations are met and consumers are able to communicate their needs, ideas, and goals to counselors, then consumers are empowered and the potential for customer satisfaction is enhanced. While not all goals may be achieved, both partners will be satisfied that an appropriate effort was put forth with honesty and in an atmosphere of mutual respect.

Counselors need to constantly remind themselves that every client is different and that the informed-choice process must be tailored according to those differences. Much attention has been given to the differences that consumers from diverse ethnic, racial, religious, nationality, and gender groups bring to the rehabilitation process. Counselors need to be knowledgeable

about and accept and build on the richness of these values, viewpoints, and needs. While the vocational rehabilitation program has always been an individualized one, diversity issues require counselors to be even more sensitive to the need for customized rehabilitation. It is important that counselors not lose this perspective when assisting clients in making informed choices. Every consumer is different in his/her ability, capacity, conditioning, values and comfort level in making decisions (which is what the informed choice process is all about). Counselors shouldn't expect that every consumer can and will help identify options, explore each of these for personal meaning, and make informed choices. Every consumer needs to be individually assessed, and the decision making process should be adapted to the consumer. In some cases, training to build skills and comfort levels to better prepare the consumer to participate in this process may be indicated. But even then, care must be taken not to "force fit" a consumer to a mold that may be contrary to his/her values or beliefs.

The process of making informed choices may also need to be modified for disability related reasons. The consumer should not be excused from the decision-making process because of a conscious or subconscious preconceived and erroneous assumption by the counselor that the consumer cannot do something. People do not learn, do not really accept a decision, unless they've had an opportunity to try, to seek out alternative ways to achieve what needs to be done, and to have pride that, to the maximum extent possible, they did it their way. A danger of being in a helping profession is that the professional may feel the need to do too much for the consumer. The world of accommodations and "high tech" now makes it possible for consumers to do things themselves and to participate in ways that they never could before. Counselors need to consider *how* they can make it possible for consumers to personally participate in the informed-choice process, not excuse them from it. For example, talking computers now make it possible for consumers with limited vision to "read" printed vocational information material that they may not have been able to read before.

The wealth of information in computer data systems now makes the exploration of options much easier for the consumer who has mobility limitations than in the past. Laws now require that vendors of needed rehabilitation services be accessible to consumers, opening options that may not have been possible before. The challenge for counselors is *not* to limit options and *not* to limit the consumer's participation because of real or perceived barriers but to focus instead on *how* to make it happen.

Even the consumer who is intellectually limited and whose scope of occupations and range of options seem so limited as to make choice meaningless can nevertheless make choices. Not all choices need to be big ones; even the small ones count. Choices made at the level of the consumer's ability are as meaningful to that person, and give just as much a sense of participation and satisfaction, as the choices made by consumers with greater intellectual capacity.

Even the consumer who is significantly developmentally disabled can and should be given the opportunity to make choices - "What color socks would you like to wear today?" "Would you like to eat lunch inside or outdoors on the picnic table?" Choices are only part of it, however. The role of the counselor is to ensure that choices are *informed* choices, not just choices made without any considerations:

Q. "Let's see; your black socks are nice and match the slacks you're wearing; your blue socks are warmer and it's rather cool today; and then there's the new red socks you got for your birthday -- which ones do you choose to wear?"

A. "I think I'll wear the red ones; Betty will be there today and red's her favorite color."

The point is, counselors need to be as resourceful as possible in making certain that consumers have the fullest opportunity possible to identify and explore options to the maximum extent of their ability and at a level consistent with their capacity.

Counselors not only need to keep in mind the consumer's cognitive and affective functioning when considering how to maximize consumer informed-choice opportunities but also need to ensure that the mode of communication is one that is consistent with the consumer's communication skills and needs. Interpreters; translators; and audio, video, and written materials are all options that should be brought into the informed-choice process as needed to supplement or replace verbal communication when they will make the process more meaningful for the consumer.

Sometimes, for the consumer to feel comfortable in the informed-choice process, or because others will be affected by the consumer's decision, or because there is a legal need to do so, others may need to be included in the informed choice process. Those may be family members, a legal guardian, a representative designated by the consumer, or someone from the Client Assistance Program.

Counselors need to be certain that consumers are aware of the effect wages have on benefits they already may be receiving from Social Security, medical coverage, or other sources once they begin working. The counselor needs to teach gradual benefit transition planning or arrange for a center for independent living to do so. Information should be included on Social Security work incentives: how to keep Medicaid and Medicare, how to use Plans to Achieve Self- Support or Impairment Related Work Expenses to gradually add income without abrupt loss of benefits, and to provide funds for training, vehicles, job accommodations, equipment, business startup, ongoing extra medical costs, job coaching or other disability-related supports needed to ensure job retention. There should be no surprises when the consumer goes to work!

While the 1992 Amendments to the Rehabilitation Act speak specifically to the informed-choice process in regard to the IWRP (§ 100(a)(3)(c)), good professional practice and the overall intent of the Act seem to clearly indicate that the consumer should be involved in making informed choices throughout the rehabilitation process beginning with application ("This is what vocational rehabilitation is all about; do you wish to apply?") to case closure ("We've reviewed and agreed that your employment seems suitable and everything is going well; is it time to close your case?"). Making informed-choices is not something that can be turned on and off. Once into it, the consumer can't just shut it off, and consumers often don't just get into it without some idea of what it's all about and possibly some practice. Thus, involving the consumer early on in the case - for example, in helping to determine the diagnostic and evaluation processes and the vendors who provide these services - helps prepare the consumer for the often more complex and numerous decisions related to the IWRP. Keeping the consumer involved in informed-

decision making after the IWRP is implemented helps ensure that it stays relevant and results in a meaningful outcome for all partners. It makes good sense to begin the partnership and the informed-choice process with the very first meeting between the consumer and counselor, and continue it until the case is closed.

The following display summarizes the role and responsibilities of the counselor in ensuring that consumers have the opportunity to make informed choices. The counselor's responsibility to say "no" when "no" is needed is also identified.

Counselor Role and Responsibilities

- To use his/her valuable counseling skills to encourage and support the reluctant, hesitant, insecure, doubtful, and defeated consumer to become a partner.
- To make certain the consumer is aware of all relevant options.
- To share responsibility for identifying options with the consumer - "*partnership at work.*"
- To be aware of the consumer's dream - to seek it out if it's not apparent.
- To involve the parent if the consumer is a minor, or a legal guardian if the consumer has one, or any other person selected by the consumer in the choice process.
- To recognize that, in a partnership, the consumer has an equal responsibility to do the "*research*"necessary to identify and analyze options.
- To make certain the consumer is aware of the implication of each option.
- To consider options from the consumer's point of view.
- To understand choices are not *"informed"* choices unless they are based on the pool of options remaining after the possibilities have been identified, considered, and the less preferable options discarded by the consumer.
- To give the consumer the benefit of the doubt when things are "*iffy.*"
- To be sure the choices consumers make are truly their choices; that choices have not actually been made for them; or that consumers have not been consciously or unconsciously conditioned by a family member, guardian, teacher, or other well-meaning individual.

Counselor Role and Responsibilities (continued)

- To allow and encourage the consumer to stretch, to take some risks, to actualize potential.
- To avoid letting severity of disability stand in the way of believing the consumer has choices and the choosing should still be the consumer's, and to remember that there are accommodations and high-tech solutions to many difficult obstacles and it may be only a matter of seeking them out.
- To include the effect of wages on benefits now being received as they assist consumers in making informed choices.
- To advocate on behalf of the consumer when needed to ensure access to other programs and resources.
- To remember that every consumer is different and that individuals who share the same characteristics, whether gender, race, age, culture, or disability, are unique and should not be stereotyped.
- To say "no" when "no" is needed and to help the consumer understand that the universe of choices is not infinite. It is important for the consumer to understand that funds, availability of resources, danger to self or others, legalities, or the job market may limit some choices.
- To always be learning and growing so that both consumers and counselors bring state-of-the-art knowledge to their role in partnerships.
- To share and to dare and to care.

Consumer

From the start vocational rehabilitation has achieved outcomes which often seem remarkable to consumers, families, and society as a whole. It has restored people to work whose work lives have been severely disrupted; it has helped people with disabilities who may still be seeking their first employment experience. It has greatly increased self-support among people formerly considered totally unemployable.

Range of Consumers. In recent years rehabilitation has modified its focus to emphasize service to those individuals who are the most severely disabled. Professionals have creatively designed ways to test and expand consumer capacities resulting in successful work experiences.

Most people with severe disabilities can now do some form of paid work in some form of work setting.

Rehabilitation now serves a full range of consumers - low or high functioning, single or multiple needs, dependent or independent personalities and at many different stages and levels of adjustment to their disabilities.

For some consumers, it is important to include family members, guardians, case managers, or significant others who serve as advocates. These individuals may be realistically concerned with consumers losing essential medical benefits and other benefits. At the same time, they may need to be cautioned not to overly protect the consumer to the extent that it interferes with the consumer's ability to exercise his/her potential.

Informed Choice. Consumer informed-choice calls for rehabilitation to become more consumer-driven, and less system-driven. The new model requires development of training and support strategies designed to help consumers become more active participants in the process of their own rehabilitation when this is needed.

Informed-choice was mandated in response to consumer advocacy. The goal is to strengthen a true partnership between skilled counselors and informed consumers. Consumers want counselors who will help empower them by ensuring access and equity in services, building their capacity for making personally meaningful choices, respecting their informed choices, and ensuring that outcomes will continue to improve their lives after rehabilitation ends.

Agency Constraints. Consumers have the responsibility to recognize that sometimes counselors need to say "no." State agencies face realistic problems with government mandates, policies, purchasing requirements, and regulations. Budget cuts and debates about entitlement may affect funding. Consumers may need to work with lists of providers permitted by state procurement laws and restrictions. At the same time, agencies may have to reconcile the need to account for public funds spent with the need for flexibility and innovation in providing consumer-responsive services and supports.

Consumers retain the right to appeal counselor determinations through due process procedures, if they disagree with those decisions. Staff from the Client Assistance Program can help the consumer understand what vocational rehabilitation can or cannot do or assist with appeals.

Consumer Responsibility. With consumer informed choice comes consumer responsibility, with counselor help, to identify, research and test options, explore what's possible and feasible, test reality, and implement informed choices. The consumer may learn independently that an option isn't realistic and abandon it. If feasibility is debatable, trial and error may help the consumer decide.

In any of these outcomes, consumer choice becomes beneficial: the counselor doesn't have to know everything, and the consumer is learning life skills useful in job keeping and career advancement.

Consumer's Informed Choice Process and Reaction to Disability. It is important to recognize that career and life planning are processes which take time, especially for people who have encountered disruptive life experiences

When consumers first realize the extent of their disabilities, most must grieve their loss of careers or hopes for careers and sometimes of relationships, loss of quality of life, and loss of long-term goals and dreams. This grieving may include parents, family members, and others. It is even more depressing - though eventually extremely useful - to be informed about vocational barriers resulting from these disabilities. Some consumers develop depression and must work through that depression.

For meaningful and informed choice, the consumer's own process of gaining motivation and goals is equal in importance to the process and technology of eligibility determination. It is right after the identification of specific vocational barriers, when expectations and hopes may be low or unrealistic, that consumers must generate job plans. This is not to say that rehabilitation counselors are to replace therapists. However, where painful job-related issues are part of the problem, these issues cannot be ignored.

Consumers exhibiting Post Traumatic Stress Disorder and grief might have feelings of indifference that alternate with feelings of being overwhelmed by stress. Both are confusing, and add to consumer doubts and denial about themselves and their abilities. It is common to lose interest in formerly important activities or in the worthwhileness of having plans, objectives, and dreams. It is common to expect not to have a career at all. Like many people, consumers may stigmatize anyone with a disability, including themselves. They must move beyond an initial sense of shame after discovering that they are not perfect.

If consumers are in any of these mind-sets, and especially if their focus is only on weaknesses and methods for compensating for them, it is difficult for them to gain hope, to remember strengths and dreams, and to make major career ladder and life choices. Consumers need validation and understanding on the part of others and assurance that almost everyone would be upset to have a career and life disrupted by a disability. They need support while they gain hope that there is a life after or despite disaster, and it may be a very good life indeed. This is especially so if they can be helped to work through grief, integrate the experience, and reframe it as a strength or even a potential new source of meaningful informed choices in their careers and lives.

The display on the next page summarizes the role and responsibilities that the consumer will have in the new rehabilitation informed-choice process.

Consumer Role and Responsibilities

- To be an active participant in his/her own rehabilitation - a *true partnership* of skilled counselor and informed consumer.
- To be open to visions of what is possible in lifelong careers, rather than settling for less.
- To be trained in problem solving by counselors who *encourage* them to make informed choices among agreed upon options.
- To choose to include family, advocates, or service providers in identifying options.
- To be a self-advocate for access and equity in services and for culturally sensitive counseling, language, and information.
- To be an active partner in helping identify options.
- To educate counselors about his/her talents, strengths, values, resources, concerns, and career dreams as starting points to explore.
- To identify his/her own barriers in making informed choices.
- To learn to offset barriers through technology, natural supports, and reasonable accommodations.
- To identify and explore a range of career options.
- To prioritize viable options based on what is best for him/her.
- To make informed career choices consistent with identified *strengths, resources, and abilities.*
- To understand that he/she can disagree with his/her counselor and present additional information.
- To learn the skills needed to keep and advance in employment on his/her own in the future without the counselor.
- To take ownership of the decisions once they are made.
- To learn to become an active partner if not already prepared to be one.
- To recognize that the universe of choices is not infinite and that the counselor may need to say "no."

Agency Administrators

Legal Requirements. As changes occur in the Rehabilitation Act, such as those presented in the 1992 Amendments, it is management's responsibility to take necessary and appropriate actions to modify the direction or operations of the state vocational rehabilitation (VR) program. The change presented by the emphasis on informed choice is not so much a new direction as it is a renewed commitment to self-determination which has long been a value of the vocational rehabilitation program.

In order to reinforce this concept, the Amendments make the state vocational rehabilitation agency responsible for ensuring that "qualified" counselors are employed to deliver services. Under Title I, Section 101 (a)(7) (Comprehensive System of Personnel Development) the Amendments require that state agencies ensure the:

> development and maintenance of standards consistent with any national or State certification or licensing requirements to ensure personnel are adequately qualified in the area in which they are providing services, and in the event that such standards are not based on the highest standards in the State, that steps are being taken by the State agency to enable personnel to meet the appropriate professional standards.

The amendments further require that:

> appropriate and adequate training programs are made available to all personnel, including continuing education and the dissemination of information from rehabilitation research training. (RSA Synopsis, 1993, p. 9)

Creating the Atmosphere to Support Informed Choice. Even more important than making the required changes is the need for agency management to acknowledge that to insure informed choice it cannot maintain the status quo. It cannot be "business as usual." Rather, the agency must accept the responsibility to create the atmosphere that will support the concept of choice and enhance the consumer's ability to select from an array of options.

Management's response in implementing changes is, understandably, to focus its attention at the counselor level since it is at this level that the job of vocational rehabilitation gets done. Therefore, in order to suggest how best to put into operation consumer informed choice, the major portion of this chapter addresses the functions of the rehabilitation counselor.

Some of this training can take the form of internal training to clarify issues. It may be necessary to clarify the definition of informed choice; clarify scope of services; identify support systems that are available or will be developed to assist counselors, etc. Some of the training may focus more directly on skills necessary to provide opportunities for informed options to clients - for example, communication skills for effective feedback, negotiating and contracting skills, and assessing labor market trends may be included.

It is obvious that ensuring "qualified" staff cannot be accomplished through training of counselors alone. Philosophy and values need to be re-assessed, responsibilities need to be

revisited, roles need to be redefined, skills need to be reviewed, strategies reconsidered, and policies continually re-evaluated for effectiveness. In order to complete all these tasks, state agencies must manage *all* their human resources effectively. There are major roles for other agency personnel to play, and management must define how each member will contribute to assisting counselors in offering opportunities for self-determination. Furthermore, management must develop objective standards for all staff members in order to effectively measure performance.

It is essential that management understand how each member contributes to informed consumer choice. In addition, management must also have a clear sense of how their functions and activities support this concept. First-line supervisors and support staff must have the same opportunity to clarify issues and definitions. Most importantly, they must understand the relationship between their job duties and how those activities ultimately support and enhance the agency's ability to assure informed choice. When reviewing a counselor's work, first-line supervisors must be able to see the relationship between their involvement with the counselor and the counselor's ability to offer informed choice. For example, the supervisor's knowledge of particular resources may provide additional options that the counselor is able to make available to the consumer.

There is also an expectation for change on the part of supervisors. New behaviors or approaches to situations will be expected from supervisors as well as from counselors. For example, in order to ensure that all viable options are considered and presented to consumers, greater risk-taking behavior must be encouraged. For supervisors, the new behavior may be learning to encourage and support these new concepts. Supervisors may see conflict with their traditional roles as "monitors" and "guardians" of public funds. If supervisors are unable to reconcile the two, or are uncertain how to deal with problems that arise, the new behaviors will not develop.

> Where change...and uncertainty prevail, the distinctions between various roles become blurred. The demand characteristics may become incomprehensible. In such situations, individuals retreat to the perceived safety of old, familiar roles. (Stroul, 1992)

Clear goals, policies, and parameters for provision of services will make it easier for supervisors to understand their roles and provide the environment that will allow change.

For support staff, it may be somewhat more difficult to see a direct relationship between their activities and direct delivery of services by counselors. Although they are generally "expert" in their particular areas of responsibility, program specialists may have difficulty in seeing the impact of their activities on the counselor's ability to offer informed options:

> Despite the fact that they are all well trained in their particular disciplines and specialties, they are not able to weave their efforts into a context of integrative unity with total organizational goals and processes. They are over-trained in the technical aspects of their jobs and under-trained in how to fully integrate their staff functions into a unified whole agency. (Hanks, 1990)

This is generally the result of lack of priorities or unclear work assignments. It may be useful for management to determine what needs the counseling staff has and then establish clear priorities and work assignments for program specialist staff with goals that relate specifically to the agency's efforts to enhance consumer self-determination and informed choice.

Needs to Provide Other Tools for Staff. In addition to knowledge and skill development, management is responsible to provide other tools for staff as well.

A primary resource would include information needed to more effectively deliver informed choice. For example, agencies must provide staff with up-to-date information regarding state-of-the-art technology: what technological services may be available to enhance employability and what career opportunities are available for consideration.

In addition, management must provide data regarding service providers in order for counselors to offer quality options to consumers. Performance assessment of providers is necessary so that consumers have a basis upon which to make a choice. This issue can be quite controversial. Some have suggested that vocational rehabilitation agencies should rank order service providers. This, of course, may imply superior ability to deliver a service. The impracticality of accomplishing this task, its possible illegality, and potential for litigation, argues strongly against such a questionable activity. As an example, however, consumers can be provided with simple information such as costs, faculty composition, ratio of staff to students, placement rates, and names of companies who employ graduates of the program, etc. Generally speaking, this is public information and can be useful to a consumer in making a decision. What is important to keep in mind is that the goal is to provide sufficient data to consumers so that they can make an informed choice.

It is also essential that clear policy be developed that provides counselors the parameters within which they may operate. There is a wide range of services offered by state vocational rehabilitation agencies. However, informed choice is distinct from unlimited choice. In order to be effective in establishing options for consumers that the agency can support, any limitations to these services and the conditions under which they may be provided must be clearly defined:

> The vocational rehabilitation (VR) system can enhance this portion of the VR process by allowing a wide variety of potential services - a virtual cafeteria of possibilities - to be chosen in providing the best options for the consumer. Informing and allowing counselors to use these options has its place in helping them to become knowledgeable about possibilities. The system then enhances the client/counselor partnership through the freedom of the counselor to provide the best possible services as opposed to allowing the consumer to be "a kid in a candy store" choosing one or more of each possible service. (Corthell & Van Boskirk, 1988, pp. 65-66)

Marketing is also an essential responsibility of management. For external customers, the agency must develop appropriate material in all media that clearly describes the services of the agency and the concept of informed choice. Public information must be directed at a wide range of audiences, i.e., consumers, referral sources, school systems, and employers.

However, agencies often neglect to do any internal marketing to their own staff when trying to reinforce new ideas or behaviors. Without having its staff "buy into" its goals, the agency risks failure at achieving change. A specific internal marketing plan must be developed which outlines how the concept will be presented, internalized, and monitored for effectiveness.

Marketing will also require serving on committees and boards to inform others of the concept of consumer informed choice and how it affects those who are our partners in the community. The development of cooperative agreements, as well as strong positive relationships with other community-based organizations, will create a positive image and ultimately enhance consumer/counselor interactions.

Finally, management must also take the time to assess its achievements towards assuring informed options for consumers. Studies should be commissioned to determine compliance with required changes, success of new behaviors and techniques, the value and effectiveness of resources provided to staff, and consumer satisfaction. And most importantly, management must provide regular and ongoing feedback to staff about these results.

The following display summarizes the role and responsibilities that vocational rehabilitation administrators should attain as the customer informed-choice process developed.

Administrator Role and Responsibilities

- To have a vision and commitment to the concept of consumer informed choice.
- To create an atmosphere that enhances and encourages optimum choices for consumers.
- To be alert to opportunities to improve the way things are done.
- To take actions to modify the operations of the state agency when indicated.
- To ensure that qualified counselors are employed by the agency.
- To establish clear priorities and work assignments for program support staff consistent with the concept of informed choice.
- To provide adequate and appropriate training to all staff members.
- To clarify for counselors the scope of services and the support systems available to ensure a consumer informed-choice service delivery model.
- To provide counselors the necessary resources, such as information regarding technology, data regarding service providers, placement tools, etc., in order to optimize consumer choices.

Administrator Role and Responsibilities (continued)

- To develop cooperative agreements with community organizations in order to enhance consumer/counselor interactions.
- To clearly communicate agency philosophy and values as they relate to informed choice.
- To develop appropriate material in all media that clearly describes the agency's services and the concept of informed choice for a wide range of audiences.
- To review and modify, when necessary, policies of the agency to ensure consistency with the concept of informed-choice.
- To clearly define responsibilities of all agency personnel and their role in the consumer informed choice model.

Supervisor

Knowledge and Understanding of Concepts. The supervisor has a critical part to play in reinforcing the concept of informed choice. The role is not a new one:

> In most instances, it is the first line supervisor who sets the tone in the local rehabilitation office. Top management depends heavily on the first line supervisor to implement agency policies and procedures. Basically, the supervisor is responsible for planning, directing, budgeting, controlling, and many other management functions.... The supervisor should be fully aware of present legislation, client needs, federal guidelines, and the benefits that can result from client participation and involvement. (Rice & Orsburn, 1975, p. 71)

To assist counselors to function under the consumer informed-choice model, the supervisor must become familiar with the amendments, subsequent regulations, and any state agency policies that affect consumer options. The supervisor must clearly understand the concept and the implications presented by the amendments. Supervisors must assess counselor competency in skill areas needed to successfully employ the consumer informed choice model. Finally, supervisors must make a commitment to these requirements and specifically to the concept of informed consumer choice.

Supporting the Counselor's Role. Although "choice" has for a long time been a value of the vocational rehabilitation system, the requirements being placed on counselors today have resulted in changes to their role. While choices may have been offered in the past, they were usually offered after counselors had, in their own professional judgement, determined what were

the best options for the consumer. Now, selection of service providers may take more time because of the need to provide more in-depth information; counselors will be required to do more negotiating; more in-depth vocational assessment and exploration may be necessary in order to provide career development options.

With the removal of the eligibility requirement of feasibility, as well as the new emphasis on careers, counselors are now encouraged to take risks in seeking solutions to vocational problems. The supervisor's actions must demonstrate encouragement and support for these new ways of thinking.

When reviewing cases the supervisor's decisions must be consistent with the principle of informed choice and efforts must be made to develop procedures which will facilitate a consumer informed choice delivery system. Likewise, the supervisor must inform management when policy development is needed to enhance the counselor's ability to assist consumers in self determination and to provide feedback to management concerning those policies which seem to be impeding the process. An excellent means to help these issues to surface is to hold regular staffing of cases which raise choice issues.

It is management's responsibility to provide the necessary training to counselors to make them as effective as possible in providing informed choice. However, it is a primary role of the supervisor to act ass a direct trainer. The supervisor coaches, shares knowledge of service providers, and shares experiences about a wide range of employment possibilities.

The following display of responsibilities makes it clear that the supervisor's role is an integral part in a system that values informed consumer choice.

First-Line Supervisor Role and Responsibility

- To be familiar with legislation, regulations, and subsequent state policies that affect consumer options.
- To clearly understand the concept of informed choice and its implications for the delivery of services.
- To assess competence needed by counselors in order to implement informed choice.
- To provide training and remediation to counselors in order to ensure that optimum choices are being made available to consumers.
- To encourage risk taking behavior in counselors when considering options with consumers.

First-Line Supervisor Role and Responsibility (continued)

- To demonstrate support for new counselor behaviors that enhance informed consumer choice.
- To ensure that all decisions are consistent with the principles of informed choice.
- To develop procedures that will facilitate a consumer informed choice delivery system.
- To provide feedback to management concerning policies that appear to be impeding consumer self-determination, and to identify when policy is needed that would enhance self-determination.
- To act as coach and mentor for counselors, sharing knowledge and experiences in order to enhance options made available to consumers.

Agency Program Staff

In state vocational rehabilitation agencies, interdependency between field and program staff is complex. When change is occurring, attention is often focused on the system that is the target of the change. In this instance, the field must implement informed consumer choice and generally, the focus is on how the organization will affect these changes in field offices. What is sometimes overlooked is that as changes occur in one system, these changes have varying degrees of impact on other systems (such as administration or program staff). Being highly interdependent, they too are now faced with the need to change. However, there may be resistance as staff struggle to maintain the status quo.

Being a skilled technician is not enough for a program staff person. Staff need to be sensitive to the culture and nuances of the organization. They must be the visionaries for the agency, anticipate possible changes in focus or direction, and be sensitive to new trends. Unless management establishes clear goals, sets priorities, and assigns work tasks based on needs identified by counselors, program staff may not see the relationship between their activities and their contribution to the overall goal.

With the added emphasis on information in order to provide consumers with options, the role of the program staff becomes even more critical to the field counselor. As experts in their program area they can be valuable resources for information regarding technology and service providers, formulating policy to enhance consumer informed choice based on identified needs, functioning as a clearinghouse for information which can be collected, evaluated, and disseminated. "They can effectively gather information, analyze it and generate alternatives to solve complex problems...." (Hanks, 1990).

There is, however, mutual responsibility to secure this result. The field staff must be sure that their work is useful and consistent with the agency goals; and field staff must provide regular and useful feedback for the services they provide.

The relationship of program staff to the overall goals of the agency, and to informed consumer choice in particular, must be apparent to the individuals in those positions and to others as well. Their role and responsibilities can be seen in the following display.

Program Staff Role and Responsibilities

- To be visionaries; to anticipate change in direction; to forecast possible new trends.
- To gain sufficient knowledge in their program area to become the "technical expert" resource for the agency in that subject area.
- To be the resource for information about technology, service providers, and facilities.
- To identify needs and help formulate policy which will facilitate an informed choice service delivery model.
- To function as a clearinghouse regarding resources related to their program area.
- To collect data and evaluate effectiveness of programs and providers.
- To ensure that their work activities are consistent with, and contribute to, the agency goal of an effective informed choice delivery system.

Other Partners

Responsibilities of Other Partners. Just as there are vocational rehabilitation responsibilities in assuring informed choice, there are also responsibilities that fall to the partners of vocational rehabilitation to assure that choice will take place. While these may not necessarily be specifically identified in a formal written agreement, it is essential that vocational rehabilitation personnel communicate them clearly to their partners.

Vocational rehabilitation's partners must become knowledgeable about the vocational rehabilitation program. They must understand its mandates as an eligibility program as opposed to an entitlement program. They must become familiar with the scope of services vocational rehabilitation can provide and under what conditions they may be provided. They need to understand the changes brought about by the 1992 Amendments, specifically those requirements

surrounding consumer choice. They must acknowledge that in their interactions with mutual student/consumers, they will be expected to maximize self-determination by assisting to identify options. Finally, as partners, both must continue to work to develop community resources to enhance the array of options from which consumers may choose.

The Role of Community Rehabilitation Programs and School Systems. Among the many partners with which vocational rehabilitation develops cooperative relationships, two in particular warrant further discussion: community rehabilitation programs and school systems.

Community rehabilitation programs have been partners of vocational rehabilitation agencies for many years. As a result of their long history of providing vocational rehabilitation services, they have established ties to the business community, financial resources, and skills and experience with personnel. Today, with greater emphasis on placement in integrated settings and supported employment, community rehabilitation programs must renew their efforts toward the goal of incorporating these concepts in their service delivery system:

> While Supported Employment as a service is not a new concept, it provides a new direction to services traditionally provided by sheltered workshops. The new element in service is that Supported Employment will be with community-based employers rather than within the workshop setting itself. Although many workshops throughout the country have operated Supported Employment programs, it has generally been as an adjunct to the "on site" workshop program. (Rice & Pankowski, 1985, pp. 67-68)

If community rehabilitation programs are to be effective partners in providing viable options for consumers to make informed choices, then they must find ways to incorporate their resources into strategies which will allow the partners to achieve these goals.

The second entity with which vocational rehabilitation has a rather unique cooperative relationship is local education agencies, i.e., school systems. Noting that the transition from school to work is a difficult one for all young people, legislators recognized that this transition is even more difficult for young individuals with disabilities. Past legislation acknowledged the value of this coordinated effort but required only that vocational rehabilitation work cooperatively with schools. The 1992 Amendments to the Rehabilitation Act direct state vocational rehabilitation agencies (just as the Individuals with Disabilities Education Act [IDEA] directs school systems) to develop policies that will assure that vocational rehabilitation agencies cooperate with state education agencies so that students exiting the schools and requiring rehabilitation services receive uninterrupted services.

Responsibility for transition planning is now a collaborative effort between the vocational rehabilitation agency and the school system. The Individualized Education Program (IEP) and the Individualized Written Rehabilitation Program (IWRP) must be coordinated so that there will be no gap in services. It is this unique collaborative effort of professionals that will provide greater options as the student transitions to work:

> ...effective transitional programming is marked by each discipline drawing on the knowledge of the other professions. For example, vocational educators will not

necessarily be experienced in adapting core education curriculum to the unique training requirements of persons with a variety of disabling conditions and resulting in functional limitations. Special educators can assist vocational educators in breaking down required tasks into component steps and in adapting class activities so that students with disabilities can fully participate. Vocational rehabilitation staff can identify to special educators the focus of the local labor market and advise on structuring longitudinally sound career exploration and early work experience programs. (Corthell & Van Boskirk, 1984, p. 31)

In order to accomplish the goal of transitioning students, local education associations have very specific responsibilities implementing IEPs for transition planning. They are responsible to coordinate the transition team, to implement a long-range planning process for the student in order to identify future education and employment opportunities, and to follow-up with other agencies.

In order to execute these transition activities responsibly, they must have a substantial knowledge of the vocational rehabilitation system and how it works. They must understand the concept of vocational rehabilitation as an eligibility program and the implications this might have to families who are used to having all their needs met under entitlement programs, such as education. They must understand that vocational rehabilitation cannot be the panacea for all school related problems but that the vocational rehabilitation role is a consultative one - a role which will help to identify resources and plan for the future needs of the student. They must understand what vocational rehabilitation can provide and under what conditions services can be provided.

It is the responsibility of vocational rehabilitation personnel in this regard to "educate" the educators and all its partners about the vocational rehabilitation system. There should always be room for interprofessional differences. And disagreement, if managed correctly, can be beneficial. Individuals learn and grow from discussing differences with others.

However, it is essential that as professionals all partners respect each consumer for his/her individual dignity, self-determination, and pursuit of a meaningful career. "Without this approach, the old 'caretaker' attitudes and approaches take over" (Rice & Pankowski, 1985, p. 56).

If the vocational rehabilitation system can keep these values in mind as it discharges its responsibility within its many cooperative relationships, it will be able to meet the goal of greater options for self-determination through informed choice.

Developing Cooperative Relationships. Informed choice does not take place in a vacuum. The vocational rehabilitation process must develop effective relationships with a wide range of organizations and programs if it is to be effective in its service delivery.

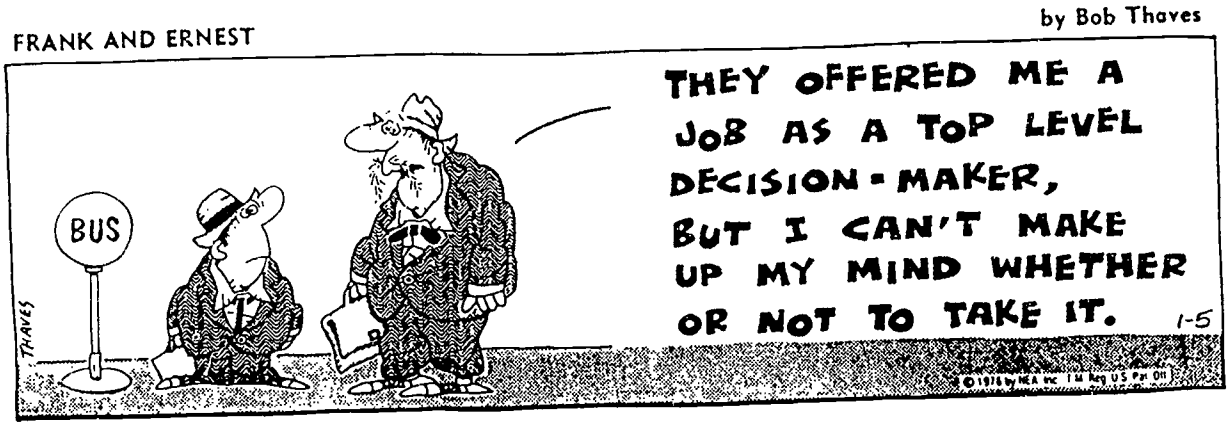
Sometimes these affiliations or partnerships are required by law (for example, the 1992 Amendments which require vocational rehabilitation agencies to coordinate services with school systems for transitioning students). Sometimes the relationship is formalized in an agreement

of cooperation or sometimes it is an informal affiliation in which the parties agree to consult with each other as necessary. Few would disagree that there are advantages to cooperative relationships. However, being advantageous is not enough. Administrators must establish a foundation for the working relationship and must be aware of the potential barriers to organizations effectively working together.

Communication issues usually head the list of items that may enhance effective cooperative relationships. Partners should have a clear understanding of the responsibilities of each party in order to obtain or furnish information. They must have a clear understanding of how and under what conditions information will be shared. One way to improve overall understanding and enhance chances for successful cooperation is through joint orientation of staff to describe the goals, objectives, and methods each party will be using. Roles of individuals may be described; joint policies developed; implementation and operational procedures outlined.

Conversely, among elements which create barriers to working cooperatively are included imprecise definition of agency responsibilities" and "absence of the common procedures for information dissemination" (Rice & Cato, 1988, p. 33).

Likewise it is essential to describe to the partners how effective the agreement is in meeting its intent. Evaluation of the cooperative program must be continuous with feedback to all parties. This must include how well the goals and objectives are being met. It should also identify problems that might suggest needed modifications to the agreement.



(A new challenge for many consumers. . . . . .)

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Chapter IV

How to Operationalize the Process

Introduction

This chapter provides a format for implementing consumer decision making within the vocational rehabilitation process. First, it examines when the process should begin and when ground rules should be established. Second, it focuses on the importance of professionals' utilizing their counseling and guidance skills to foster informed choice; additionally, this section also looks at vocational rehabilitation as a service and the responsibility of both the counselor and the consumer within this partnership. Third, counseling skills are explored; i.e., How does the professional encourage informed choice within the partnership? Fourth, documentation is an important aspect of rehabilitation and is considered within this section. The fifth section of the chapter addresses strategies to empower the consumer and reduce conflict. Some suggestions and examples are provided as a starting point both for counselors and consumers. Finally, the chapter concludes with a review of some selected pilot projects from around the country.

When Does the Process Occur?

The process of involving a consumer in his/her rehabilitation begins with an attitude, and it begins before the counselor and the consumer meet. The attitude must be present in the counselor initially, and if it is not present initially in the consumer, then all efforts should be made to help the consumer develop it. It is an attitude that underlies the rehabilitation process, and for the counselor it includes respect for persons with disabilities and recognition of their potential to make appropriate choices regarding their own lives. For the consumer, it includes self-respect as a person with a disability, and belief in one's own ability to make choices in one's own life. It is recognized that individuals have differing abilities and skills in making decisions and choosing their life course; however, persons with disabilities should have the opportunity to develop and to make maximum use of their skills. Thus the process hinges on the presence of an attitude first in the counselor and then in the consumer, and it must be present early in the meetings of counselor and consumer.

Morrissey (1994) points out that choice is a dynamic process, and the consumer can decide to choose or not to choose a particular option. During career exploration, ability and interest assessment, job search and job acquisition, an individual will be presented with choices and will be able to suggest additional options at key points in the vocational rehabilitation process. Consumers will enter the process at different points, with varying degrees of preparation, and the counselor should be sensitive to this and provide appropriate, customized assistance. Information will need to be presented differently due to the individual's disability

and point in life, e.g., whether he/she is a recent high school graduate, college graduate, or dislocated worker.

The first meeting between counselor and the consumer is crucial since it is here that the ground rules and expectations for each partner's roles are defined. The counselor has a number of things to convey to the consumer, including rights and responsibilities. Attitudes are also communicated. The tone is set for the entire process during this meeting. Thus the counselor should communicate an attitude of respect and the fact that the consumer has a major role to play in decision making, choosing options, and taking responsibility for his or herself. Hopefully, consumers can also convey their readiness and expectation for doing this. At this point the decision is made by both as to whether or not to continue the process. If the decision is made to continue, then both decide which diagnostic services are required and which vendor will provide the service.

The next decision point is when the counselor decides whether the consumer meets the criteria for acceptance for services. If accepted, the consumer and counselor together develop the rehabilitation plan or the extended evaluation plan. Decisions about what services are needed, who provides them, and the vocational goals or objectives, are made at this point. The Individual Written Rehabilitation Program (IWRP) is the outcome of these deliberations. Documentation of the consumer's role in the development of the IWRP is required. One reason for the IWRP, aside from its planning value, is to identify and focus on the consumer's role in the planning process.

The completion of the IWRP is a shared responsibility, and the counselor and consumer is each responsible for completing some of the IWRP documents. A problem with the IWRP is that the written requirements may be too difficult for some clients, especially those who may be limited intellectually, may have learning disabilities, or other factors limiting their use of written materials. The IWRP should be presented to each consumer in an understandable manner.

Client informed choice in the area of selection of services and providers is an important issue when considering consumer involvement. Effective decision making requires information; some consumers may have limited access to, and experience with, information concerning the areas about which they must make decisions. Hence, it has been suggested that the state agency provide consumers with basic information about the services and the providers so that the consumer may make informed choices. This information may take the form of a file kept on each provider that includes comments from previous users of the service, or their names and phone numbers, or compliance of the provider facility with recognized standards for their service. Each state may develop its own methods to aid the consumer with appropriate data.

The IWRP is developed just prior to entering service status. Choice points occur at least annually during the required IWRP review; reviews may occur more often as indicated. The IWRP may be modified according to the needs of the consumer at any time during the process.

When consumers are ready for employment, they face major decisions and choices. Where do I look for work, what employer, what wages, how do I prepare for interviews, and

how much help do I need? Many of these questions will have been anticipated and the appropriate decisions made before the consumer is ready for employment.

Consumers who have learned how to make informed choices, who trust their own abilities, and have an internal locus of control will be able to move on from the rehabilitation process to lead independent lives. They will have used the rehabilitation services that they needed and will go on to deal with the choices and decisions that all people face in society. Their expectancy will be to rely on themselves, while still being aware that help is available if needed and if they choose seek it.

Rehabilitation programs other than those in the state-federal system also have an important role to play in helping consumers become independent decision makers. Community-based rehabilitation facilities, Associations for Retarded Citizens, Centers for Independent Living, and Mental Health Centers all have services that can help individuals learn decision-making skills and how to make appropriate choices. Services aimed at helping individuals gain self-confidence and develop an internal locus of control include individual and group counseling, assertiveness training, career counseling, job clubs, programmed work experience, and social skill training. An important key again is that the program have an attitude and philosophy appropriate for facilitating self-responsible behavior.

Rehabilitation counselors take on roles as educators in terms of helping consumers learn skills that will facilitate their own rehabilitation, but many counselors find themselves without the time or the experience to do this. Thus, in some instances they refer consumers who lack these skills to programs such as those mentioned in the previous paragraph. These programs then may become the focus of programming for consumers to learn decision making and independent living skills.

The Importance of Counseling and Guidance in Implementing Formed-Choice

Value of Counseling as A Service

The importance of vocational rehabilitation counseling and guidance has been documented by the Institute on Rehabilitation Issues (IRI). In this document, consumer involvement with regard to choices is mentioned as an essential factor for increasing the awareness of professionals to strengthen such services (November, 1993). Consumers want and have the right to make choices that will have a profound effect on the direction of their lives. This is especially true when talking about career and vocational choices. The rehabilitation professional's role in the process provides the structure for the individual to make those choices. This structure is the guidance process.

Counseling is the process that may be needed when clarification of values and other issues become a part of the decision-making process for the consumer. Vocational counseling experts such as Tolbert (1980) and Zunker (1990) maintain that decisions about occupational and career choice require individuals to have a sound understanding of themselves, a comprehensive

knowledge about the occupational opportunities available, and a thoughtful career-planning process. The vocational counseling process can typically help these individuals develop more insight, acquire necessary vocational skills, receive emotional support during any retraining process, and learn the techniques necessary to explore various occupational opportunities. Of course, the specific counseling strategies used will vary depending on the unique needs of a particular consumer.

Encouraging Risk Taking

Rehabilitation professionals are committed to facilitating personal, social, and economic independence of individuals with disabilities. Informed choice should be viewed as an empowerment concept which encourages maximum independence of the consumer. By assisting the consumer in making informed choices, the counselor places responsibility on the consumer. By exploring options, the rehabilitation counselor encourages risk taking.

Clearly, risk taking is a normal human behavior. We take chances in many things we do. Usually we do things that involve odds that are in our favor, so we should encourage our clients to also take risks. Risk taking inspires consumer ownership for the decision.

Obviously, encouraging consumers who need help in accepting responsibility takes time and effort. Some may view public vocational rehabilitation as a system that fosters dependence by giving consumers all of what they want when they want it. Some consumers may view such programs as an entitlement and not one that is eligibility-based. One could argue that informed choice could very well backfire if vocational professionals do not have the freedom to work with consumers and say "no" as appropriate. Otherwise "informed choice" could be a vehicle for some consumers to misuse the system. Consumers cannot learn from their mistakes when the system provides all the services and the consumer risks nothing.

Counselor Obligations

Ethics is defined as the study of values in human conduct or the study of correct conduct. It is not an exact science but is rather an attempt to state and evaluate principles by which ethical dilemmas may be resolved. It provides a way to help an individual organize his/her thinking to determine the best course of action in the face of conflicting alternatives. Ethics offers a critical, rational, defensible, systematic, and intellectual approach for determining what is right or best in a difficult situation.

Rehabilitation professionals who hope to practice in an ethical and legal manner cannot take the rights of consumers for granted. A part of ethical practice is talking with the consumer/client about his/her rights. The Code of Professional Ethics for Rehabilitation Counselors states (Journal of Applied Rehabilitation Counseling, 1987, Winter).

> Rehabilitation counselors will honor the right of clients to consent to participate in rehabilitation services. Rehabilitation counselors will inform clients or the clients' legal guardian of factors that may affect clients' decisions to participate in rehabilitation services, and they will obtain written consent after clients or their legal guardians are fully informed of such factors. (p. 27)

Other professional organizations that offer counseling as a service recognize informed choice as a consumer right. The American Psychological Association (Corey, Corey, & Callanan, 1993) states "psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational or training procedure, and they freely acknowledge that clients, students, or participants in research have freedom of choice with regard to participation" (p. 417).

Consumers may not realize that they have rights. Because they are sometimes vulnerable and desperate for services, they may unquestioningly accept whatever is offered. Therefore, it might be easy for professionals to abuse their authority with regard to providing services. It might be more convenient to steer the consumer in the direction that will require less paperwork, counseling and guidance time, case dollars, all leading to a quick, successful closure. Consumers who have been treated in that manner often use state vocational agencies as a revolving door. In the long run, such action can increase use of case dollars, require more counseling time, and is a disservice to consumers. It would be more productive not only from a case management standpoint but from a practical one to initially spend the necessary time in promoting consumer involvement within the rehabilitation process. According to the Rehabilitation Counseling Code of Ethics, it is the professional's responsibility to inform and provide consumers with information throughout the rehabilitation process. It is an ethical, practical, and morally sound practice to inform and empower these consumers to make the right choices for themselves.

Professionals have a responsibility to consumers to make a reasonable disclosure of all significant facts, the nature of the rehabilitation procedures, and probable consequences and difficulties. Regardless of their capacity to understand, all consumers have the right to have the process and services explained to them. Bednar, Bednar, Lambert, and Waite (1991) assert that it is essential for consumers to understand and give their consent voluntarily. It is the responsibility of professionals to assess consumers' level of understanding to protect their free choice.

An ethical dilemma can exist when agency policy restricts service delivery. For instance, when two service options differ in cost and are comparable in quality, agency policy might supersede consumer choice. In these situations, the counselor must clarify agency policy and explain why a particular option cannot be provided. However, it is essential that when agency policy restricts options, then the counselor should explore alternatives that meet the consumer's needs.

Offering Alternatives

> "We owe almost all our knowledge not to those who have agreed, but to those who have differed." (Charles Caleb Colton)

There is a shared philosophy goal among all rehabilitation professionals that restoring people to their fullest realistic functioning levels is the optimal goal (Rubin & Roessler, 1987). In situations where rehabilitation professionals feel that the evaluation results do not support consumer-chosen goals, it is important that professionals realize that saying no or disagreeing with the consumer is acceptable. Disagreement should not be viewed as a need for the

consumer-counselor partners to take an adversarial posture in the working relationship, but it should be seen as a potentially positive factor in the decision-making process. Therefore, disagreement should be seen by the rehabilitation professional not as a situation that questions their professionalism but as a bargaining tool that is used to eventually come to some mutual agreement. The concept of informed choice should be viewed as strengthening the professionalism of the rehabilitation counselor by empowering consumers thorough assessment and good decision-making skills. Moreover, such a situation can give the rehabilitation counselor an opportunity to see the issue from the consumer's perspective and, hopefully, to develop a compromise.

Disagreement should be viewed as a learning process in that it may place more emphasis on educating both parties on "why" the disagreement exists, encouraging education and sharing of information relative to that decision. If goals are deemed unrealistic by the rehabilitation professional, the reasons for that conclusion are shared. This might create an opportunity to do some reality testing with that consumer. This could create an atmosphere for exploring other issues and possibilities.

Counseling persons with disabilities frequently involves helping them make realistic assessments of their strengths and limitations and assisting them to learn how to adjust and compensate for any known limitation. Because disabling conditions are sometimes experienced as blockages or frustrations that may cause feelings of anger, the counseling process should include helping consumers assess their coping skills. When necessary, the consumer should be given the appropriate assistance to overcome nonconstructive feelings and emotions and develop more constructive coping strategies.

Counselor Skills

The work of the counselor includes determining eligibility for vocational rehabilitation services, reviewing medical data, obtaining information from consumers about their goals and interests, referring counselors to other organizations or support systems, and identifying problems that might interfere with future employment opportunities. Counselors explain agency policy and procedures, as well as the rights of the consumer to appeal; and they also determine the need for assessment testing based on an analysis of the information gathered. Finally, the counselor develops an Individualized Written Rehabilitation Plan identifying services, objectives, and time frames needed for the consumer to reach his/her goals; and the consumer, if he/she agrees, signs the plan. However, if the consumer has not been involved in making any choices regarding the plan and the sole planner has been the counselor, this is a situation that should be changed.

According to Ferris (1995) "collaboration is the new era of service delivery, meaning that consumers should be involved with their rehabilitation planning and procurement." Ferris states that consumers would be more satisfied with the rehabilitation process and likely to be more successful in obtaining employment if they are allowed to take full responsibility in making decisions concerning their employment goals and required services. Consumer involvement is no longer optional. It is not a matter of "should" be involved, but rather "must" be involved as

clearly expressed in the 1992 Amendments that state: "Congress finds that disability is a natural part of the human experience and in no way diminishes the right of the individual to ...enjoy self-determination" and "individuals with disabilities must be active participants in their own rehabilitation program..."

The following are some of the skills that rehabilitation professionals should possess in order to collaborate effectively with consumers as partners.

Negotiating/Contracting

Negotiation is a process in which individuals or groups seek to reach a goal by making an agreement with each other (Johnson, 1993). As a communication skill, the ability to negotiate effectively can contribute substantially to the collaboration process between consumers and rehabilitation professionals. Conflict is inevitable when resources are limited and counselors must attempt to balance their responsibilities to the public at large against the desires and preferences of individuals. These conflicts, however, can be managed if mutually satisfying contracts can be developed between both parties through negotiation.

Effective negotiating is facilitated if both parties have goals that they can share and articulate. The Individual Written Rehabilitation Program is an ideal vehicle for this type of goal clarification. Counselors must encourage consumers to identify their needs in order to clarify short- and long-term rehabilitation and vocational goals.

Negotiation and contracting presume that both parties are equal in the relationship; otherwise, one party can simply order some outcomes to occur. The ideal process assumes from the start that the consumer is an active participant.

The consumer's responsibilities in this process include planning; attending meetings; and articulating goals, values, and objectives. The counselor's responsibilities include building and establishing a rapport in order to understand the consumer's point of view and helping the consumer explore values and goals.

Problem Solving and Decision Making

Problem solving is a systematic strategy for the logical analysis of a problem using steps that allow one to arrive at a solution for implementation (IRI, 1993, November). Since consumers may be confronted with the need to solve problems at various points in the rehabilitation process, it is essential that counselors determine the consumer's ability to apply this skill.

Consumers who are skilled at problem solving may occasionally have difficulty in finding an effective solution to a problem. The counselor's role then is to assist the consumer by clarifying the problem and offering different approaches for consideration. However, "People have difficulty solving problems because they either never learned how to solve them or they feel the problem is overwhelming" (Cormier & Cormier, 1991, p. 386). In these instances the counselor must be aware of the feelings this may engender in a consumer when confronted with a problem (for example, anxiety, feelings of inadequacy, hopelessness, loss of control, etc.).

Counselors must be prepared to offer a model for problem solving, including fundamental steps and basic techniques.

Decision making has been defined as "the process of choosing from among two or more *unequal* alternatives to solve an immediate or long-range concern or to exploit an immediate opportunity (Brown & Brooks, 1991). Decision making styles vary with individuals, and it's helpful for both partners to understand their own decision making styles. When the counselor's style differs from the consumer's, this needs to be recognized so that they can work effectively together. Whether one prefers to be logical and follow a systematic process, or to respond intuitively by what "feels" right, or to function alone or within a group makes considerable difference in the decision process. Ivey, Ivey, and Simek-Morgan (1993) pose some helpful questions that the counselor might ask in assessing decisional styles:

> Is your decisional style rational and logical, or is it more intuitive and creative? Do you make lists of factors involved in important decisions and weigh the decision carefully, or do you have some inner sense of what made that decision 'feel' right?
>
> How much are you influenced by others when you make a decision? Do you make the decision alone or in relation to other key individuals or family members?
>
> How does creativity relate to your decisional process? Can you generate something new in terms of a product or how you and others behave, think or feel. (p. 72)

They also point out that cultural factors are important in this process, in that white, male European-North Americans tend to be individualistic and to make decisions individually. Women, and many other cultures, on the other hand, tend to be more relational in orientation, and to take the context into consideration; extended family and group members are important. When working with consumers from African-American, Latino, and Asian-American cultures, Ivey et al. (1993) say it is important to emphasize the relationship of the individual in context within his or her environment (p. 73).

Benjamin Franklin is generally credited as being the first to outline the practical problem-solving method as an aid in decision making. His model can be a helpful tool for a consumer in making decisions. Although it is widely used, it does not emphasize context of the problem. Ivey et al (1993) define their model as follows:

1) Define the problem or concern clearly.
2) Generate alternative possibilities for solution.
3) Weigh the positives and negatives of each alternative in a simple *balance sheet*.
4) Select one alternative for action and see how it works out." (p. 72)

Other models for problem solving presented by Strickland (1978), Krumboltz (1966), and Egan (1975) that can be helpful to consumers are cited by Corthell (1993): Strickland includes:

"a) identify the problem, b) identify values and goals, c) identify alternatives, d) examine alternatives, e) make a tentative decision, f) take action on the decision, and g) evaluate the outcome" (p. 34).

Krumboltz recommended: "a) generate a list of all possible outcomes; b) gather relevant information on feasible alternatives; c) estimate probability of success in each alternative; d) consider personal values; e) deliberate and weigh facts, outcomes and values; f) eliminate least favorable course of action; g) formulate a tentative plan of action; and h) generalize the process to future problems" (p. 34).

Egan proposed: "a) identify and clarify the problem, b) establish priorities in choosing problems for attention, c) establish workable goals, d) take a census of available means for reaching the goals, e) choose the means that will most effectively achieve established goals, f) establish criteria for effectiveness of action programs, and g) implementation" (p. 35).

Ivey et al. (1993) have developed a model for counselors to use in decision making counseling that can be used to emphasize the consumer's role in the process. The outline of their approach is as follows:

1. Establishing rapport and structure. ('Hello, this is what we'll be doing today.') Note: responsibility can be shared, e.g., "What would you like to do today?"

2. Gathering data and identifying assets. ('What's the problem or concern?' and 'What are your strengths?')

3. Determining outcomes. ('What do you want to have happen?')

4. Generalizing alternative solutions. ('What are we going to do to generate new ideas?')

5. Generalizing and transferring learning. ('Will you do it?') (p. 77)

The authors suggest using this outline as a checklist and to use it flexibly to meet the needs of the individual consumer. The method can help the consumer to identify concerns, strengths, goals, and creative options and to use this information in making life decisions. The consumer's role as decision maker is basic to the process.

Counselors need to listen carefully to the consumer and to ask relevant questions in order to facilitate the consumer's decision making and independence. Brown and Brooks (1991) point out the importance of clarifying expectations early in the counseling process to understand what the consumer expects of the process. Suggested questions include:

1. What do you hope will occur as the result of counseling?

2. How do you expect attainment of these goals to occur within the context of the counseling process?

3. What role do you expect to play in your own goal attainment?

4. What role do you expect the counselor to play in the attainment of your goals?

5. How long do you expect the process to take? (p. 18)

Once expectations are defined, then roles can be clarified so the consumer and counselor are working together as collaborators, rather than with the counselor being seen as the expert.

In making decisions, there are techniques that can structure the decision making process and improve the process itself. In career counseling, there are a number of decision-making aids available to counselors that can be used by consumers. By helping to structure the process, these aids can help the counselor and consumer work together. Brown and Brooks (1991) have described several aids, including the "force field analysis," "elimination by aspects," "balance-sheet approach," and "subjective expected utility approach" (pp. 278-285.).

The "force field analysis" is especially helpful in identifying those forces that hold consumers back from making decisions and those that promote successful decision making. The "elimination by aspects" approach helps decision makers by focusing on only one aspect of the alternatives available at a time. The "balance sheet approach" is an adaptation of Benjamin Franklin's method but is more sophisticated and for each decisional alternative assigns weights to possible gains and losses to self and others and to self and social approval ratings. The "subjective expected utility approach" helps the decision maker by considering the value (utility) of the benefits that will result from the choice and the probability of the value being realized as a result of the choice.

As an example, in using the "elimination by aspects" approach the consumer might identify five aspects that are important in a job, e.g., income potential, advancement opportunities, limited travel, security, and location. Then, in considering available job opportunities, each job is considered in light of these five aspects. Jobs are eliminated or continued to be considered based on how they meet these aspects. This method is especially helpful in narrowing choices, rather than in making final choices (p. 280).

In working with individuals with cognitive impairments, counselors need to modify their approach to take into account the individual's specific level of decision-making abilities. Modifications to consider include keeping the concepts and the language simple, specific, and concrete. Avoid abstractions and complicated concepts in talking about the decision and the various alternatives. Keep instructions at the individual's level, i.e., think about one alternative at a time, or compare two specific alternatives, but do not complicate the process by dealing with too much information or too many options at one time. Make sure the individual has ample time to consider the decision without feeling pressure to decide, if possible. Be aware that persons with a cognitive impairment may decide to agree with what they perceive the counselor favors, just to be agreeable. When asked if they understand the problem and the options, they may say "yes" without really understanding the options; it is important to check this out. Taking the time to work individually with consumers with cognitive impairments in order to assess their level of understanding of the decision is essential.

Mediation

A mediator is a person who enters a situation to help structure a dialogue in which parties can clarify issues and work out differences. Rehabilitation counselors may find themselves playing this role under a variety of circumstances; for example, between consumer and employer, between consumer and other agencies, or between consumer and educator. Counselors may be needed to mediate within families when issues of vocational options need clarification. It may also be necessary on occasion to act as mediator between the consumer and the agency when dissatisfaction arises with policy constraints or decisions rendered.

It is essential for counselors to collect all the facts before attempting to mediate a dispute. They must understand, to the best of their ability, the perspective of each party in the dispute. They must be able to clearly describe to each party the position of the other party. They must be prepared to offer possible compromise solutions to resolve the dispute. And above all, they must remain objective and convey this attitude to all parties involved.

There also may be instances in which the counselor does not act directly as mediator but instead engages resources that may assist in resolving a dispute, for example, the Client Assistance Program (CAP). Although too often seen only in an adversarial role, if viewed as a partner when there is a dispute between the agency and the consumer, the Client Assistance Program can be a valuable resource in helping to clarify the reasons that certain decisions were made or particular options presented to a consumer. They may be able to lend support to a decision rendered by the agency and assurance to consumers that their rights with respect to "informed choice" are in fact being protected. Conversely, should Client Assistance Program's investigation identify information that suggests other options not previously considered, the goal of the agency to ensure consumer empowerment and self-determination can only be enhanced.

In whatever situation counselors find themselves, it is important to remember that "the key role of the mediator is to establish a climate of trust so that the parties feel safe enough to explore their differences" (Zartman & Berman, 1982).

Career Counseling

The 1992 Amendments emphasize the "pursuit of meaningful careers" as a goal for individuals with disabilities. To understand the impact of this statement, it may be helpful to make a distinction between some of the terms used to describe this process.

In *Counseling and Career Guidance in the Rehabilitation Process* (IRI, 1993, November) the distinction is made between career guidance and career counseling. Essentially, guidance is defined as information giving. Guidance may include referring an individual for testing, explaining the results of those tests, referring them to training programs, and providing information about occupations.

Career counseling, on the other hand, is defined as "a structured, systematic interview and a teaching process intended to help the consumer discover and articulate his/her vocational interests and goals. It is a type of counseling that has as its aims identification of vocational alternatives and the construction of a strategy to select an attainable goal" (IRI, 1993,

November, p. 51). It implies that the counselor must go beyond the concept of securing "suitable placement." In interactions with the consumer, the counselor " promotes identification, exploration and articulation of personal needs and desires.... The assistive process becomes career counseling when it includes exploring how those needs, desires, likes, dislikes, fears, etc., pertain to possible career choices" (pp. 51-52).

The counselor must consider consumers' values, interests, skills and social needs over the course of their vocational lives. The goal is to assist consumers to develop more in-depth plans that outline an occupational path that will define their vocational future. It goes beyond establishing a short-term goal of employment.

> There is a need to emphasize the importance of helping consumers into jobs that will have long-term value for them as opposed to entry-level and often short-term jobs--in other words, a career rather than simply job placement." (IRI, 1993, November, p. 52)

Counseling and Career Guidance in the Rehabilitation Process (IRI, 1993, November) also discusses problem characteristics of consumers who may best benefit from career counseling:

1. **Self-image Problems** - Some people appear to the counselor to have more potential for growth than their presenting vocational goal suggests. Career counseling can help shape their view of themselves and their long-term potential.

2. **Unrealistic Vocational Goals** - Counseling is aimed at helping the individual find a realistic goal in which he/she can succeed. The counseling is aimed at turning possible failure into success.

3. **Undetermined Vocational Goals** - Some consumers have no idea what they want to do. They have identified that they need and want help. They are cooperative and motivated.

4. **Unspecified Vocational Goals** - Some consumers say "I'll take anything," which is rarely accurate. Everyone has values, deeply held beliefs developed in childhood. These beliefs are basic and for each individual define such issues as good from bad, desirable from undesirable, beautiful from hideous, etc. These people are in the most desperate need of career counseling. Their "I'll take anything" denotes not only desperation but also vocational confusion. They are, however, the most difficult to interest in career counseling because they are desperate for immediate employment. They need the services but may not be receptive, as they perceive they need a job right now. (pp. 52-53)

In addition to having and using necessary counseling skills such as empathy, active listening, building trust and rapport, etc., career counselors can only be effective if they are prepared with information that can be analyzed and presented to the consumer in a meaningful

way. Vocational assessments have for a long time been viewed as an appropriate way to secure objective data that may identify vocational strengths and limitations, isolate rehabilitation problems, and suggest strategies for remediation.

To use test information effectively in counseling, the testee or consumer needs to understand the rationale for using that particular test (or tests). In addition, the individual being tested should also be involved in decisions made from test results and should understand the interpretation and meaning of the test results. Then the consumer is in a position to make observations, inferences, and hypothesis about their own future. In other words, the consumer is now able to make his/her own use of the test results as well as the professional.

As helpful as this information may be, the counselor must not neglect to use the single most important source of information: the consumer. Incorporating this direct input from the consumer along with objective data will increase the likelihood that consumers will be making meaningful, informed choices and will be active participants in their own rehabilitation.

One means of accomplishing this is offered by Ferris (n.d.) who outlined a training module for counselors. The model facilitates empowerment as a precursor to making decisions; to ensuring the consumer's ability to satisfy basic needs; and to providing counselors with information about the consumer's values, skills, and choices for a career.

Ferris further suggests that counselors have consumers answer the following questions to assist in gathering information and teaching consumers to make informed choices:

1. Why do I want a job?
2. What do I expect to get out of a job?
3. What do I like about working or having a job?
4. What don't I like?
5. Why would an employer hire me?
6. My top interests are _____.
7. My highest job values are _____.
8. My abilities and personal qualities that may be helpful in a job are:_____.
9. My 'ideal' job choice is_____.
10. My 'realistic' job choices are _____.

The responses to these statements will provide a basis to clarify career issues and, along with other information, define options.

The result of the structured career counseling process is that the counselor teaches the clients the skills to manage their careers. The counselor has assisted the consumer to clarify and articulate values and needs pertinent to career goals, and the consumer feels comfortable with career choices already made and feels confident to make future career decisions. All test results should be shared with the consumer and considered when developing vocational options.

Cultural Diversity

"Culture may be described as consisting of behaviors, beliefs, values, language and material objects of a group" (Corthell, 1993, p. 26). For rehabilitation counselors, it is an important factor that has a significant impact on the counseling relationship. Attention to its implications is essential if the counselor is to develop trust with consumers and enhance the process of informed choice. Counselors must remember that every consumer is different and that the informed choice process must be tailored according to those differences.

Within the counseling relationship, the consumer and counselor bring to that partnership their own personal values, beliefs, and cultural awareness. It is through these values and beliefs that each person views and evaluates the environment. If counselors are to provide information to consumers that is meaningful, they must consider the cultural perspectives of the consumers. What might be viewed as viable options by a counselor may be viewed quite differently by a consumer when filtered through different values or beliefs.

This understanding of culture must be broad. The counselor must have an understanding of the society in which the consumer lives since within a culture there can be many sub-cultures.

Additionally, it is just as important that the counselor be aware of his own cultural values and how they influence his perception of consumers and their actions or behaviors:

"An open-minded counselor seeks an understanding of his/her own cultural values, attitudes, beliefs, behaviors, and develops an awareness of how these might come into play in a counseling relationship" (Corthell, 1993, p. 26).

In order for counselors to enhance the partnership with consumers, they must be culturally competent. Cultural competence may be defined as the ability of individuals to see beyond the boundaries of their own cultural interpretations, to maintain objectivity when dealing with individuals from cultures different from their own and to interpret and understand the behaviors and intentions of people from other cultures non-judgmentally and without bias. In other words, the rehabilitation counselor must have no only self-awareness but also cultural awareness. Maintaining the consumer-counselor relationship takes into consideration the unique ways in which cultural differences affect the counseling process. Individuals with different cultural backgrounds respond in different - perhaps unique-ways to the rehabilitation counseling process.

The importance of these issues is echoed by Sue and Sue (1990) who outline important characteristics necessary to be culturally skilled: Culturally skilled counselors work toward a goal. Culturally skilled counselors become aware of their own values, behavior biases, and personal limitations. Culturally skilled counselors attempt to understand world views ,

understand consumer values, and attempt to develop sensitive intervention skills.

The willingness to assess one's own cultural awareness, values, and beliefs is a necessary condition for the counseling partnership, but it is not sufficient. It is also necessary for the counselor to identify strategies that may be employed in order to be culturally responsive and strengthen the consumer/counselor partnership.

Culturally Responsive Strategies (Durate & Rice, 1992):

1. Identify and build on cultural strengths.
2. Develop an understanding of the community - its norms, values, leaders, and resources.
3. Make use of resources and institutions unique to a given culture.
4. Be aware of your own values, assumptions, and stereotypes and make sure you are open to challenge.
5. Develop cultural competence in attitudes, knowledge, and skills.
6. Take services to the community.
7. Develop and use multicultural practitioners.
8. Focus on building trust.
9. Promote, promise, and practice culturally responsive services. (p. 50)

When counselors are working with a diverse group, the key focus is on the individual not the entire group. It is essential for counselors to always keep in mind that an individual is a person first and a member of a group second.

Making Informed Consumer Choice Work

> 'Consumer choice' at its best reflects the basic need of each individual to participate as fully as possible in his or her own destiny; values the need to assess the quality of services; recognizes that informed consent is essential if any intervention is going to be successful; and explicitly recognizes the need to preserve mutual respect between a consumer and a provider of services. At its worst, consumer choice fails to consider the needs of others, ignores community norms, promotes and encourages a litigious relationship between consumer and provider and compromises the delivery of effective and responsible services funded through public resources for all citizens. (McKenna, 1994, p. 4)

The following characteristics adapted from Morrissey (1994) can be applied in defining

an appropriate informed decision-making process:

Availability of information. Relevant information is readily accessible throughout the decision-making process.

Comprehensibility of the choice process. Information is in an appropriate (and/or customized) form that permits both understanding of information content and how the information may apply to an anticipated choice.

Pertinence of information. Information is both relevant and sufficient to anticipated choice and can be applied to decision making.

Timeliness of decision-making. Information is provided and made use of in a reasonable and timely manner so that it can affect decision making.

Effect of process on choice. A reasonable relationship between choice and information process can be shown.

Utility of the informed choice process. The scope and conduct of decision making are in keeping with the importance of the choice situation.

Consequences of choice. The need underlying the choice situation and satisfaction with result of choice are understood. Reasonable expectations can result from an informed choice.

Problem Situations

Counselors and consumers sometimes confront problems when working together and when making choices regarding rehabilitation issues. Successful outcomes depend on how these situations are confronted and dealt with. Brown and Brooks (1991) identify several problem situations that occur commonly in counseling.

Perhaps the most common situation is when the consumer has *few or no readily identifiable interests* and has difficulty coming up with vocational directions to pursue. This is often the result of inexperience and a lack of information about occupations, or the world of work. Consumers who present this problem often have little experience with work or little experience with the working world. Adolescents, women with limited work experience, isolated cultural minorities, and persons with disabilities who have not worked are often seen in this group. Consumers who are not self-directed, who are depressed, or who have low self-esteem sometimes present this problem.

In this situation, it's important to clarify how the two partners will work together: therefore, early dialogue is essential. Gathering information to fill the experience gap will be necessary and how to do this will be a joint decision between counselor and consumer. Brown and Brooks (1991) suggest self-exploration, identifying likes, dislikes and interests, and experience in work-related activities:

Self-exploration activities include:
keeping a log of activities, and analyzing it for clues;
thinking about previous likes and dislikes;
taking a standardized test battery;
getting feedback from family and friends;
occupational bibliotherapy.
Identifying likes, dislikes, and interests includes:
generate a list of occupations;
reading about them in the *Occupational Outlook Handbook* (U.S. Dept. of Labor).
Experience in work-related activities:
volunteer or part-time work;
job-shadowing (observe a worker on a job);
on-the-job evaluation;
interview workers about their jobs, e.g., friends, family members. (p. 205)

Corthell (1993) includes a number of additional sources of occupational information including libraries, career centers, professional journals and societies, and other U.S. Department of Labor publications such as the *Dictionary of Occupational Titles*, and *The Guide for Occupational Exploration*.

Unrealistic or self-limiting aspirations provide another problem situation. This is an area that requires particular sensitivity on the part of the counselor because defining what is realistic or unrealistic for an individual can be extremely difficult. It is particularly difficult to predict future performance based on current disability, especially with a young person. (One of the authors of this document, for example, was once turned down for rehabilitation services because the counselor considered him to be "too severely disabled" to benefit from services.) Both over- and underestimating one's abilities can be limiting. Realism involves assessing both suitability and accessibility.

In working with this situation, the goal for the counselor and consumer is to try to develop a realistic view of the consumer's opportunities and abilities. The purpose is not to try to persuade or steer the other in a specific direction. Realism includes anticipating consequences of choices.

For a consumer with a recent disability, not returning to a previous job may include loss issues such as identity, self-esteem, status, and finances. The counselor and consumer have to discover and work through these issues in order for the consumer to think realistically. Several counseling strategies and techniques are available that include methods such as attribution theory and cognitive restructuring techniques. The goal is to help the consumer shift self-perceptions and attributions in a more realistic direction.

Occupational exploration is useful in this situation since it provides consumers with basic up-to-date information about specific jobs and careers in which they are interested. Information about how the different job requirements meet consumer attributes and their interests, and the likelihood that work will be available, is also useful.

Consumer "resistance" or noncompliance is an indicator of a problem in the counseling

process. It may be an indication that the consumer does not have a sense of partnership or adequate control in the process. It is an expression of an unmet need on the part of the consumer, and may represent the consumer's response to what is perceived as a threat. Some counselors talk of the "unmotivated" consumer; generally this means the counselor is working with a highly motivated consumer, but one whose motivation is different from the counselor's. It is important that consumers understand resistance when it influences their involvement in their own rehabilitation. Resistance may be a function of the consumer, the counselor, or the rehabilitation system. For example, the counselor may have been unclear in communication, or the public aid agency may threaten to cancel the consumer's medical benefits if the consumer earns a minimum wage.

There are some common sources of resistance in the consumer-counselor relationship (Brown & Brooks, 1991). Anxiety about change is an example. Fear of failing, as in a job interview, is another. Anticipated loss of secondary gains (such as money, attention, security) and avoidance of responsibility are others.. Some social networks such as gangs, or highly protective parents-guardians, may support resistance. A consumer who has strong dependency needs may hesitate to become actively involved, or one who lacks assertiveness skills may have trouble following through on commitments.

Much has been written about dealing with resistance, especially by psychodynamic theorists, and also about noncompliance, by behavioral theorists. One of the major preventions is to make sure communications and expectations are clear and agreed upon by both counselor and consumer early in the counseling process. Adequate structuring and goal setting that is mutually agreed upon is necessary. Generally, if resistance or noncompliance occurs, and if it is interfering with rehabilitation goals, the most effective approach to dealing with it is to talk about it directly.

Brown and Brooks (1991) summarize two methods that counselors can use to deal with resistance. First, clear initial structuring and goal setting and then proper pacing of the counseling process will help prevent noncompliance. Second, the counselor can use "progressively more direct responses" to the consumer's concerns that are "permission giving, that address the defense, or that interpret the conflict" (p. 221).

A simple, but often overlooked, method that can be employed to help counselors gain insight into problem situations. Joint staffing of a case with other professionals can provide an objective assessment of the situation and often generates ideas or suggestions for resolution that might not have been considered by the counselor alone.

The following sample case study is offered as an exercise for the rehabilitation professional to consider the issues surrounding the implementation of informed consumer choice.

Case Study Involving Choice Issues

Assessment of Eligibility

R. Smith was referred to the rehabilitation agency four years after graduation from high school. During the intervening years she had attempted to find work but stated that she was discouraged "by employer discrimination and not really knowing what I want to do.

During the first meeting Ms. Smith and her rehabilitation counselor discussed her interests (watching television, going to the movies, and reading), her successes in high school (she was an "average" student who enjoyed math, hated spelling and loved history), and her interests in work ("a steady job that lets me use my brain and use a computer").

Her rehabilitation counselor also discussed her disability (Multiple Sclerosis) and resulting functional limitations to employment including weakness, spasticity, ataxia and tremors that interfered with her walking and ultimately necessitated a wheelchair for mobility.

Her rehabilitation counselor explained how they could use her interests, school experiences, and hobbies as a way to explore job options. The counselor also talked about the kinds of information that would be needed to assess eligibility. Ms. Smith volunteered to provide a copy of her Supplemental Security Income (SSI) award letter as a means to establishing the presence of an impairment. Ms. Smith also detailed the factors that she saw as barriers to preparing for a job and working.

Assessment of Vocational Choice and Rehabilitation Needs

In the process of considering vocational objectives, Ms. Smith and her rehabilitation counselor focused on two areas:

1. Identifying issues such as seating, positioning, and keyboard access that would enable Ms. Smith to use a computer for further evaluation; and

2. Exploring job options that might use computers as a tool to build on her strong reading skills.

The counselor and Ms. Smith talked about the issues of computer use. The counselor noted that there was only one source for computer evaluation (ACME Center) in the state—a two hour drive away. Ms. Smith did not want to go away from home for the evaluation. Her rehabilitation counselor noted that arrangements could be made for an occupational therapist to come to the home and complete an evaluation but also noted that the results would likely be less informative about hardware and software options. The counselor suggested that Ms. Smith talk with volunteers at the Center for Independent Living who had completed the ACME evaluation. After talking with others who had used a variety of evaluations, Ms. Smith elected to participate in the ACME evaluation.

During this time, the counselor and Ms. Smith began to talk about job options. Ms.

Smith preferred to work near home and stated a preference for little or no formal training. The ACME evaluation identified strengths in typing using a spell checker and an abbreviation-expansion program. Data entry was ruled out due to problems with speed and Ms. Smith's preference for greater variety. Since Ms. Smith enjoyed talking with people, the evaluator suggested that consideration be given to employment as a customer service representative. The evaluation also provided a list of seating, software, and hardware recommendations that would be needed.

Ms. Smith liked the idea of work as a customer representative. The counselor, however, recommended that Ms. Smith participate in an on-the-job evaluation so that she could gain work experience and a sense of the job demands. Ms. Smith wanted to begin a job search immediately, noting "I've been sitting for four years! "However, as the counselor and Ms. Smith began to talk about transportation, work hours, and job interviewing skills, Ms. Smith noted that she had not considered these issues and agreed that the on-the-job evaluation would be a place to start.

Her rehabilitation counselor proposed four sites for on-the-job evaluation. Initially, Ms. Smith responded,"You decide, you'll know what's best." The counselor discussed the importance of Ms. Smith interviewing each of the four sites to determine which seemed most comfortable, accessible, and interesting. After visiting three of the sites, Ms. Smith began an eight week on-the-job evaluation at a local insurance company. Her choice was based, she said, on ease of transportation. For the evaluation, the agency arranged for the employer to provide an adjustable work surface and provided wrist supports that Ms. Smith could take with her if she went to another work site. The counselor also purchased a recommended keyboard, compatible with most IBM systems.

The first week was very successful. Ms. Smith reported enjoying the work, looking up and sending policy information. During the second week. however, Ms. Smith walked out of the evaluation. She had experienced an abusive caller and stated, "I'm not willing to deal with people like that!" Her rehabilitation counselor and the supervisor discussed the need for training in dealing with angry customers and customer complaints.

As the discussion about job responsibilities ensued, Ms. Smith began to talk about "some emotional problems" she had encountered during high school. Ms. Smith noted that she had experienced severe depression and was hospitalized on two different occasions. As they talked, the counselor asked whether Ms. Smith thought she needed to be in treatment or to be involved in other supportive services. Ms. Smith noted that she was no longer taking any medication; she was not interested in traditional treatment but asked whether some of the customer training could be combined with supportive help.

The counselor talked with the employer about the type of training that might be provided to deal with difficult customers. The counselor also suggested that Ms. Smith contact at least two possible sources of training. After discussing several training options with Ms. Smith, the counselor recommended that she participate in individual training and see a psychologist. Ms. Smith responded "psychologists don't deal with the real world." After discussion, the counselor and Ms. Smith selected the option of individual training coupled with peer counseling, with both services provided by the Center for Independent Living.

As the peer counseling and training proceeded, Ms. Smith volunteered that she was beginning to realize that her energy level, transportation problems, and SSI issues were more complicated than she had realized. After discussion, Ms. Smith considered a traditional job-seeking skills clinic, a work adjustment program, and additional peer counseling. Both the counselor and Ms. Smith had observed growth in Ms. Smith's self-confidence and her interpersonal skills. These improvements were seen as an outcome of peer counseling. Based on this progress, Ms. Smith determined that she preferred peer counseling that would focus on the issues of transportation, energy conservation, and Social Security Work Incentives.

After completing the training and initial peer counseling, Ms. Smith reported that she felt more confident about dealing with "difficult customers" and felt ready to complete her on-the-job evaluation. The results of the evaluation were positive; however, the insurance company was unable to hire Ms. Smith due to a reduction in force and Ms. Smith's reluctance to accept evening hours.

Rehabilitation Plan

The counselor and consumer jointly agreed on a job goal of customer service representative. Together, they determined that the peer counseling was providing effective support and should be continued on a twice monthly basis. Ms. Smith received placement assistance from the agency's marketing and employment specialist. Given her involvement throughout the planning process, Ms. Smith was able to describe her participation in planning and developing the Individualized Written Rehabilitation Plan.

Placement and Follow-Up

When Ms. Smith found employment, she stated that she felt prepared to market her excellent product information skills, accuracy, and organization. She was also prepared to identify accommodation needs and describe the services her rehabilitation counselor could arrange and provide. The counselor and Ms. Smith were able to negotiate a part-time job. While this meant that Ms. Smith was not eligible for health benefits, it did provide greater flexibility with transportation, match her level of physical and psychological endurance, and with Impairment Related Work Expenses excluded, kept her income at a level that allowed her to retain her SSI payment and Medicaid benefits. The employer, with Ms. Smith's recommendation, provided a headset and modified keyboard.

After two months on the job, Ms. Smith felt ready for case closure. She had been able to arrange transportation with a co-worker. Her skills in dealing with difficult customers had been noted positively by both co-workers and her supervisor. She continued to keep her hours limited as a way of dealing with fatigue but viewed herself as "really enjoying work." Ms. Smith did not anticipate a need for post-employment services but did continue to stay in touch with her counselor.

Questions for Discussion

The following questions, in part precipitated by the preceding case history, are examples of those a rehabilitation professional might encounter when counseling consumers to make

informed choices.

1. To what degree does this case study present opportunities for the consumer to make informed choices?

2. At what points in the case does the consumer exercise informed choosing?

3. How might informed choice issues be addressed if Ms. Smith were unable to read and/or had difficulty with memory, decision-making, or abstract thinking?

4. How might you address the situation where the consumer comes to the initial meeting with firmly fixed ideas about needs, services, and vendors?

5. How might you address the situation where the consumer says, "I don't want to bother with this -- you're the expert, you decide!?"

6. How might you address the issue of the consumer selecting a vocational goal which is unrealistic?

Documentation

Purpose of Documentation

Although documentation is considered by many as simply the paperwork that gets in the way of doing the job, most rehabilitation professionals acknowledge that it serves many purposes of the rehabilitation process:

> ...case recording...should serve as a diagnostic aid; should be a learning device for the counselor; should provide evidence of service; should be used in evaluation..., should facilitate supervision; should facilitate data collection; should aid in determination of the client's eligibility for services; should facilitate review of the legality and wisdom of administrative decisions; should provide teaching aids for beginning counselors; should facilitate research; and finally, should prevent duplication of previous interviews and make for continuity of services. (MacDonald, 1963, p. 10)

If the purposes are many, the reason can be stated simply:

> ... it is part of what you must do in the profession of rehabilitation. It can be difficult. It can be time consuming. But make no mistake, without documentation the most dramatic rehabilitation success can be overlooked if the file cannot show through the written word (documentation) how the counselor helped to make a difference in the client's rehabilitation. (Hanks, 1986, pp.19-20)

Documentation is important because it will highlight those actions that demonstrate how

the counselor made a difference in the vocational rehabilitation process. It will also serve to clarify to others (e.g., supervisors, administrators, auditors, etc.) that those decisions were executed in accordance with legislation, regulations, and/or policies.

Since one of the purposes of documentation is to provide evidence of service, the case record should provide a substantial rationale for all decisions regarding services and vocational objectives. A review of past literature for advice on how to accomplish this understandably emphasized the role of the counselor. It suggested little guidance in the way of demonstrating consumer involvement or participation. Many would argue that the reason for this is because the vocational rehabilitation process was viewed differently in years past; i.e., that it was a reflection of a medical model that provided "expert" advice to bestow benefit to the consumer:

> It used to be that rehabilitation was something 'done' to a person. The idea was that it took a professional with training and a degree or certificate to discern what life course a person with a disability could or should be encouraged to take. Rehabilitation professionals were expected to develop the expertise to know what was possible, what was reasonable; their task was to inform people with disabilities about what they could do and help them do it. (Rehab Brief, 1994, p. 1)

Emphasis on Self-Determination and Choice

The theme of choice, increased self-determination, and empowerment permeates the 1992 Amendments to the Rehabilitation Act. It is apparent that Congress intended it to be incorporated as a value which was to be honored in all *interactions with consumers*. For example:

> Section 2(a) (3) (B) & (C): Congress finds that disability is a natural part of human experience and in no way diminishes the right of individuals to...enjoy self-determination... make choices.
>
> Section 2(c) (1): It is the policy of the United States that all programs, projects and activities under this Act shall be carried out in a manner consistent with the principles of respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers, based on informed choice of individuals with disabilities.
>
> Section 2(a) (6) (A): The goals of the nation properly include the goal of providing individuals with the tools necessary to make informed choices and decisions.
>
> Title I Section 100(a) (2): The Act's purpose is to assist states in operating a comprehensive, coordinated, effective, efficient, and accountable program of vocational rehabilitation services for individuals with disabilities, consistent with their strengths, resources, priorities, concerns, abilities, and capabilities, so that such individuals may prepare for and engage in gainful employment.

Section 100(a)(3)(C): Individuals with disabilities must be active participants in their own rehabilitation program including making meaningful and informed choices about the selection of the rehabilitation services they receive.

It is also quite apparent that Congress expects state agencies to document the actions which demonstrate that this has indeed occurred. For example:

Section 100 (a) (29): State Plans will...describe the manner in which individuals with disabilities will be given choice and increased control in determining their vocational rehabilitation goals and objectives.

Section 102(B) (1) (b) (x): Each IWRP shall include a statement by the individual, in the words of the individual, (or if appropriate, in the words of a parent, a family member, a guardian, an advocate, or an authorized representative of the individual) describing how the individual was informed about and involved in choosing among the alternative goals, objectives, services, entities providing such methods used to provide or procure such services.

Some of the requirements for documenting the ways in which greater self-determination and empowerment will be accomplished are the responsibility of the state agency. For example, the amendments require the establishment of a State Rehabilitation Advisory Council from whom the state agency will seek and consider advice; there is a State Plan requirement to "describe the manner in which individuals with disabilities will be given choice and increased control....".

For vocational rehabilitation counselors to be effective in demonstrating that this concept has been integrated into their relationship with consumers, evidence of informed consumer choice must be provided throughout the case recording narrative. However, although there is a decided emphasis on self-determination and informed consumer choice in the 1992 Amendments, this is not a completely new concept to vocational rehabilitation. It has always occurred to a varying degree in the vocational rehabilitation process. The amendments now define more explicitly the conditions which should exist surrounding choice and the manner in that it is to be demonstrated.

Generally speaking, in the past a typical case record would be worded to demonstrate the active role of the counselor as expert, while description of the consumer's interactions took on a decidedly passive connotation as a recipient. In the context of informed consumer choice, however, in order to demonstrate evidence of service, documentation in the case record must also describe the meaningful events in which the consumer has participated in making decisions as a fully informed partner.

To do so, counselors need to describe the process engaged in with the consumer To this end the counselor must be specific and deal with substantive issues. Issues needing resolution must be identified, and the manner in which the consumer was informed and involved in the process must be delineated. In general, case recording should reflect the decision-making process used by the counselor with particular attention paid to clearly describing the active roles each played in deciding the final outcome.

Although case recording must describe activities in terms of observable events, informed choice should not be viewed as a technique or tool used by the counselor only on selective "special" occasions. Counselors must have case documentation to reflect choice as a concept or a value that permeates all interactions.

Essential Documentation

There are two specific areas relating to informed consumer choice that must be addressed by the counselor. Both involve the execution of the IWRP. They specifically focus on decisions regarding service providers and choice of vocational objectives.

In the first area of required documentation, the counselor must demonstrate how consumers have been made active participants in their own rehabilitation programs, especially in making meaningful and informed choices about the selection of the rehabilitation services they receive. According to the amendments, the IWRP must clearly outline "the entity or entities that will provide the services and the process used to provide or procure such services." In order to accomplish this, the counselor must ensure that case recording reflects the process used to provide information to a consumer in order to make a choice.

An example of this is found in a case recording that describes a counseling session in which a list of vocational-technical schools was discussed with a consumer or a case recording that summarizes a counseling session describing pros and cons of a sheltered workshop versus supported employment services to the consumer and the settings in which the employment would occur. Some states already have lists of providers for specific services which are made available to counselors in order to assist in outlining options to consumers.

What is important to keep in mind is that the goal is to provide *sufficient* data to consumers so that they can make an informed choice and subsequently *demonstrate in the case recording* that this has occurred. Attention to vocabulary used in case recording can be effective in accomplishing this. For example, an entry summarizing a counseling session could end by stating: "the consumer was sent to XYZ School." Informed choice and consumer involvement might better be demonstrated by stating: "After discussing several training options, the consumer selected XYZ School."

The second area of "required" documentation entails a shared responsibility. Although the consumer is responsible to execute the action, the counselor is responsible to assure that it occurs. The 1992 Amendments now require that the IWRP contain "a statement by the individual in the individual's own words describing how he or she was informed about and involved in choosing among alternative goals, objectives, services, entities providing services, and methods used to provide or procure such services."

Consumers often have difficulty with what is expected of them in this section of the IWRP. If they do not understand the intent (that is, to confirm that they have been an active, informed participant in the decisions regarding services and career goals) or if they do not fully appreciate the process through which they have just come, their comments may be vague or not address the point. Comments such as "Thank you" or "No comment," while certainly the right of the consumer, do nothing to demonstrate that a partnership existed or that the consumer was

given an opportunity to make informed choices. Unless the counselor explores this further, this "required" documentation becomes meaningless.

More importantly, it may be a missed opportunity for both the counselor and consumer to discuss the implications of the process they have completed together. For example, for some consumers this might have been the first real opportunity to begin to explore the sense of power and control over certain aspects of their lives.

Furthermore, it is important for counselors to understand the value of services delivered within the context of informed choice. Without confirmation that the consumer truly participated in the process, the counselor has confirmed simply that services were selected by the consumer. But the counselor has not demonstrated the quality of the consumer's interactions or benefits from involvement in the vocational rehabilitation process. Stated more simply, evidence of provision of services does not demonstrate quality of the counselor's impact: "Needs identified and met are a better indicator of quality vocational rehabilitation than a list of services provided. It is possible to provide services without meeting the needs of a client" (Schwab & Fenoglio, 1992).

It is precisely this concept that the 1992 Amendments are trying to address, that is, not simply noting that participation occurred but demonstrating the quality of that interaction; not simply noting that choices were made available but that the needs of the individual, as defined by that individual, were met.

Rehabilitation counselors, by and large, do not take the interaction with the consumer in developing the IWRP lightly. But since the consumer's views section is the only place in all of the documentation of a case in which the consumer's voice is truly heard, the counselor must make a concerted effort to ensure that the consumer understands its intent and that the statements are thoughtful considerations of the part the consumer played in arriving at these life decisions. It may be necessary to provide more coaching and guidance here than in the past when simple "comments" were requested. Counselors must encourage individuals to express their perception of the process to the best of their ability.

Communication skills for the counselor are essential to accomplish this. The counselor must define, in an individualized way, the services that meet the needs of the consumer, the range of the services offered, and the options available; the counselor must use contracting and negotiating skills in order to collaborate as a partner in decisions regarding services and vocational choices; the counselor must solicit frequent feedback throughout the process. If the counselor has been effective in using these skills, the comments from the consumer will more likely reflect the intent of the amendments: "Consumers will feel free to say things much more openly if the counselor is not attached to an outcome. With a counselor agenda that is flexible, consumers will be much more open and honest" (Corthell & Van Boskirk, 1988, p. 30).

In the final analysis, documentation in and of itself is not important unless it is a true and honest reflection of the relationship between a consumer and a counselor. The words can be "made to fit" so that compliance with the law is met. But, if counselors truly value empowerment and self-determination for individuals with disabilities and if state agencies are indeed attempting to deliver a program that is to be "carried out in a manner consistent with the

principles of respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers..."(Section (a)(6)(A) of the 1992 Amendments of the Rehabilitation Act), then evidence of informed choices will be apparent throughout the case record and beyond. It will inhabit every aspect of every interaction between an individual with a disability and a counselor. And we may come to a day when proof of its existence in the vocational rehabilitation process will not be "required by law."

Strategies to Empower the Consumer and Reduce Conflict

Support Groups and the Mentoring Process

As the phrase itself suggests, "formed"choice is based on information. The value of support groups is the unique opportunity they present for consumers to process and evaluate information. In addition, peer counseling and mentoring serve to provide similar opportunities for exchanging and processing information.

The benefits of peer counseling and mentoring have been proven many times in the counseling process. The concept of "self-help" groups and the importance of role modeling are also effective tools in the rehabilitation process.

In general, support groups for consumers with chronic illnesses have proved valuable because they learn that they are not alone and that what they are feeling or experiencing is actually "normal." In addition, consumers learn that they are not as different as they thought and their feelings of isolation are reduced.

The group experience provides an opportunity for consumers to give advice, suggestions, support, and comfort to their peers. If the group is functioning properly and participants feel comfortable to be open and share, consumers can increase their sense of adequacy and self-esteem. They will also be able to accept their situation and understand it better (Yalom, 1985).

Some consumers may need more validation of their potential for success. Professional counselors who may have been consumers and who have returned to meaningful careers can be excellent role models: "If I can do it, you can do it." Their unique awareness is respected by both consumers and other professionals. They can become advocates as well as role models as they advance in their careers. Consumer-professionals can also help build respect for consumer views and improve consumer satisfaction.

Michigan Rehabilitation Services

In Michigan, staff determined that special programming must be developed with minority consumers in order to increase their opportunities to succeed in a structured program. This program was designed to be more flexible and to allow creativity when working together.

An experienced counselor and a district manager led the initial group of consumers that was comprised of ten black male substance abusers. They met on a weekly basis for a two-hour

period after normal work hours. During the meeting, a meal was served/catered, thus incorporating an opportunity for socialization among the group members.

Many of these men had absolutely no support systems. The nature of their disability resulted in total estrangement from their families. They had exhausted all of their resources and burned many bridges along the way. They needed more support than the average consumer who accesses services.

The consumers had an active role in moving the support group forward. They were also responsible for setting the ground rules while agency staff functioned more as conveners.

Part of the group time consisted of helping these consumers work through problems with other social services agencies. In addition to their advocacy role, various individuals were brought into the group as both speakers and role models for the participants.

The success of the consumers involved was overwhelming. Only one of the ten consumers did not enter training or employment. The group truly believed that Michigan Rehabilitation Services as an agency was committed to ensuring that they succeeded in the program.

Michigan Rehabilitation Services has since continued to expand the support group programs. Staff are now working with consumers whose services have been interrupted to assist with replanning and avoiding negative closures. The agency has also conducted motivation groups in which successful consumers have returned to share their experiences with other consumers.

Experience has shown us that in some situations, a more holistic approach to the rehabilitation process should be explored. Consumers have diverse needs, and it is the agency's responsibility to focus on those individual needs.

Peer Mentoring

In 1992, Santa Rosa Junior College (SRJC) in Santa Rosa, California, was awarded a grant to address the disproportionately low enrollment and retention rates of minority students and students with disabilities. *The Peer Mentoring Program and Handbook* they developed is very thorough and comprehensive (Santa Rosa Junior College, 1993).

They began by organizing a Project Advisory Committee that included representatives from both high schools and community colleges. In addition, three student peer mentor trainees were recruited to participate on the committee.

The main objectives and their actual achievements were as follows:

1. Develop a comprehensive peer mentoring training program for students by January, 1993.

   A Guidance 50 (*Peer Advisors and Counselor-Aide Workshop*) curriculum was

offered as a two-unit class. This was the core training for students interested in becoming peer mentors.

2. Recruit and enroll 40 under-represented students in the mentor training program for Spring, 1993.

   Fifty students were recruited and enrolled in the training program class. Thirty-one were of ethnic minority backgrounds and ten were students with disabilities.

3. By May, 1993, twenty under-represented students (out of 30 completers) were selected to become peer mentors.

   A total of 47 students completed the Guidance 50 course requirements and were selected to become peer mentors. Thirty of the completers were under-represented students.

4. Establish linkages with three Sonoma County high schools through outreach activities which provide contact between successful under-represented student role models (mentor trainees) and under-represented high school students and parents.

   Connections were formed with four Sonoma County high schools and four continuation high schools. Project staff and mentor trainees gave ten on-site presentations at local secondary schools. The purpose of the presentations was to inform high school seniors about the program and to encourage them to enroll at Santa Rosa Junior College.

5. In mid-June, 1993, sixty under-represented students (out of 85 identified) were to participate in a week long Summer Institute facilitated by college counselors and new mentors.

   Approximately 100 graduation high school seniors were invited to participate. They were identified and recommended to participate by their high school counselors. Unfortunately, only 18 out of the 100 actually attended.

6. Increase the visibility and recognition of under-represented students at San Rosa Junior College.

   This objective was accomplished by providing the under-represented mentor trainees the opportunity to participate in activities that supplemented their training such as cultural events, student employment, campus tours, guest presenters, etc. Participation in these activities helped increase their visibility and recognition. Moreover, a campus recognition ceremony was held honoring peer mentors who had completed the training. The college's president acknowledged the peer mentors and handed out the certificates of completion.

The college staff adopted the student peer mentoring program as a strategy for providing personal assistance to under-represented students in a predominately "white" college. An

important focus was to create a friendly climate for the new students. The mentoring model they developed was used to help reduce feelings of isolation and to make the students aware of resources.

The entire concept of the program supported the belief that peers can have a positive impact on students grades, aspirations, and life goals. Another important aim of the student course was to create a learning environment that promoted multi-cultural awareness and sensitivity (SRJC, 1993).

The University of California at San Diego developed a similar peer mentoring program to meet the needs of their students with disabilities. Their handbook entitled *Peer Mentoring: A Support Group Model for College Students with Disabilities* (1992) is another excellent resource that supports the value of the mentoring process.

Staff realized that possible problems in social adjustment, social perception, self-concept, and motivation could place these students at-risk in the university environment. Their focus became topic centered to help facilitate the development of a social support system. They dealt specifically with study strategies and interpersonal skills. The main objectives of the program were to help their students develop these skills, foster independence, and build self-confidence to improve the retention rate of this particular student population.

Business and Industry have also realized the value of peer mentoring. Major corporations such as Ford Motor company have actively conducted mentoring programs for students interested in related fields. Since 1990, they have established the Ford Academy in 37 high schools located in 12 states. Students take courses in marketing, statistics, and technology while in their high school curriculum. Participating schools work with local businesses to provide summer job opportunities.

Support group programs and peer mentoring for consumers and future consumers of vocational rehabilitation services enhance opportunities for success for everyone. One viable method of increasing the pool of role models and mentors is for more counselors to encourage consumers to explore the field of rehabilitation counseling as a career option. Many universities currently offer financial aid including stipends for candidates in the master's degree program. In addition, this option may also increase the ability to recruit and attract more staff who are culturally diverse to provide services for consumers in our changing society.

Technology

With the advent of technology and the numerous accommodations available, vocational options for consumers have increased tremendously. Both the consumer and the counselor must be well trained and knowledgeable in this area to ensure that consumers are aware of the range of services and choices available to them.

Technology has significantly impacted on the immediate access and availability of current labor market information. Many computer programs offers consumers a wealth of information relating to employment trends and educational programming requirements for various occupations.

Ultimately, the consumer must play the central role in technology and choice related decisions. In this situation, however, the consumer's responsibility may impact tremendously on his/her life choices and equipment selection long after the case services have ended.

In the rehabilitation arena, assistive technology is usually thought of as a device or service that improves a person's functional capabilities. Assistive technology is defined in the Rehabilitation Act as follows: "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of people with disabilities."

Technology has revolutionized the rehabilitation process by enabling consumers in becoming independent and more productive at home, at work, at school, and in the community.

The Technology-Related Assistance for Individuals with Disabilities Act of 1988 was reauthorized in 1994. Most of the law remained intact but the three major changes included the following:

1. Additional funding was made available. Every state is now eligible for grant funds. Over 30 states now have some type of technology project implemented. Extension grants were also awarded that increased project operations of up to ten years.

2. Each state was mandated to perform six specific systems change and advocacy activities. They emphasize outreach, interagency collaboration, and training.

3. States are now mandated to spend between $40,000 and $100,000 annually to provide protection and advocacy services resulting in systems change. The contract amounts are based on the size, population, and other characteristics of the state.

The Rehabilitation Services Administration has emphasized that the use of technology across the entire rehabilitation process by vocational rehabilitation counselors and others in the field is an expectation embedded in the newly authorized Rehabilitation Act. Some technology planning and implementation at the national level include the installation of a national electronic bulletin board to allow immediate access to grant and legislative information (Accommodation News, 1994).

The Rehabilitation Engineering Society of North America (RESNA) Technical Assistance Project provides consultation and information to states receiving funds under the Technology-related Assistance for Individuals with Disabilities Act of 1988.

Many states currently have a technology project available as a resource to consumers and rehabilitation professionals. Tech 2000 is Michigan's project and is funded by a grant from the National Institute on Disability and Rehabilitation Research, U.S. Department of Education. The mission of Tech 2000 is "to increase ready access to assistive devices, services and funding by developing linkages that create statewide systems change and an advocacy network that is consumer-driven, community based and permanent" (Tech 2000, 1994).

A previous IRI document entitled *Counseling and Career Guidance in the Rehabilitation*

Process contains valuable information relating to assistive technology. It discusses the assistive technology process in relation to problem solving and the application of the process throughout the consumer involvement in the rehabilitation program.

From a consumer standpoint, the document contains some comprehensive questions to be used in assisting the consumer in making good choices.

Consumers must be responsible and conduct research with their counselor's if needed, to review and select appropriate equipment. The *Partnership for Choice Program Handbook* relates this concept to developing empowerment skills. Learning to become a responsible consumer is another step towards empowerment (MACII., p. 77).

There may also be cases where consumers and practitioners have differences of opinion regarding the need for a selection of assistive technology. Agency policy should set clear guidelines and suggest resources available to help resolve these differences.

Many states already have local electronic Bulletin Board Systems that allow consumers, educators, families, professionals, employer, friends, and service providers the ability to communicate and share information related to assistive technology. In addition, information can be shared through a voice messaging system. There are networks available in local communities to allow free computer access to connect with these systems. This may be available through local Centers for Independent Living, libraries, and colleges, etc.

Additional resources are being developed on an on-going basis. The National Brain Tumor Foundation, for example, is currently developing a Technology Resource Guide in both CD Rom and print formats. It will eventually provide information on where to find hardware, software, and services that enhance self-reliance and productivity for people with particular disabilities.

In the recently published *Computer Resources for People With Disabilities*, the Alliance for Technology Access does an in-depth overview of assistive technology. The book was developed by a consumer-driven organization and offers extensive information including practical solutions, specific product information, technology tools, real examples of success stories, current legislation, and possible funding sources. In addition, the book contains a comprehensive listing of resources and references (Alliance, 1994).

Summary/Recommendations

Technology is changing rapidly and product availability is extensive. Counselors must be knowledgeable of resources to assist consumers in their search for products, services, and viable career options. This may include conferring on specific questions consumers should research to assist them in making educated decisions. Extensive use of technology as a resource should result in effective decision making and improved satisfaction for all parties in the rehabilitation process.

Selected Pilot Projects

When the 1992 Amendments to the Rehabilitation Act of 1973 became law, it was immediately evident that a shift in public policy had occurred. The language of the new amendments reflected a greater emphasis on "consumer choice" - the belief that the consumers of rehabilitation services have both a right and a responsibility to make their own choices.

Staff now has to explore new ways to support consumer choice. One method being utilized is by convening focus groups and forging partnerships with consumers and other community agencies.

Shared Partnerships

Testimony received from consumers and advocates prior to the passage of the amendments had pointed to a reluctance of state vocational rehabilitation agencies to accept clients as equal partners in the rehabilitation process.

The role of both the counselor and the consumers has been modified with the concept of consumer choice. Counselors must create an environment that stresses the importance of the partnership with consumers. Counselors must convey to consumers that they are the responsible, active decision makers. It is the responsibility of the counselor to help the consumers assume full responsibility for their lives (Rehab Brief, 1994).

Counselors must recognize the importance of guidance and counseling skills in order to implement the "informed choice" concept. Counselors must be effective in knowing how to elicit information from consumers. They must be encouraged to take more risks when exploring options for consumers. Counselors must also be comfortable with having to say "no" when it is warranted.

Consumers have to take responsibility for their own actions and decisions. They have to take the major role in their rehabilitation process and goal setting. They may also have to educate the counselor in terms of what is really important to them and their values.

Concern was also expressed that the biases and discrimination that exist in society with respect to the abilities of persons with disabilities are mirrored in the public rehabilitation program. This was further referenced in the 1992 Rehabilitation Act Amendments.

To help states make system changes that embrace consumer empowerment, the 1992 Amendments authorized funding for demonstration projects that would increase client control in the selection of rehabilitation goals, services, and providers.

Three states (Arkansas, Vermont, and Washington) and four private agencies were awarded federal grant funds to plan, implement, and evaluate consumer choice demonstration projects over a five-year period beginning October 1, 1993.

Program Models

Brief overviews of these pilot programs offer insights into the ways consumer choice may be integrated into the rehabilitation process. At their completion, these programs may serve as models for other states and regions, and widespread dissemination of their results can be expected (Rehab Services Administration, 1994).

Arkansas

The Arkansas Rehabilitation Services demonstration project uses a voucher system for services that facilitate choice and positive employment outcomes for consumers. A primary objective of the project is to increase the participation in Vocational Rehabilitation services of individuals with significant disabilities from traditionally underserved, culturally diverse populations.

This project encompasses a ten-county region characterized by minority populations and low income. Consumers receive empowerment training intended to improve their decision making capacity. Consumers also contract with individual case managers called "consumer connectors" to assist them in making informed decisions regarding vocational goals, services, and providers. By design, the project's staff will issue payment to service providers only after the consumer verifies acceptable service delivery.

Business councils consisting of local employers in the specific Arkansas counties assist consumers, secure job trials and develop permanent job placements. Other features include a consumer advisory committee and a cooperative relationship with the Arkansas Regional Rehabilitation Continuing Education Program to replicate the project across the state and region.

Vermont

The demonstration grant awarded to the Vermont Division of Vocational Rehabilitation is funding a collaborative project with the Vermont Center for Independent Living and the Center for Transition and Employment at the University of Vermont.

Consumer-support teams are used to implement system changes in the way rehabilitation staff and consumers perceived and negotiate rehabilitation services. Each team is comprised of a rehabilitation counselor a consumer mentor, and an eligible consumer. The team makes cash directly available to the consumer.

Unique aspects of the Vermont project include: (a) a self-employment component through which start up grants are available to consumers with self-employment goals, and (b) a three-tiered payment system that includes direct cash for purchases under $100, and expedited payment for services under $1000. Consumers attend an orientation session and may elect to attend empowerment training on topics such as consumerism, self-employment options, negotiation skills, provider evaluations, and the Americans with Disabilities Act.

Washington

The "Participant Empowerment Project" of the Washington State Division of Vocational Rehabilitation is a collaborative effort among consumers, the community, schools, advocacy groups, independent living centers, and Vocational Rehabilitation counselors to enable the state agency to permanently integrate client choice into the rehabilitation process. An independent living specialist coordinates and trains peer support counselors who are key members to the rehabilitation team assembled by consumers to provide additional assistance in services planning.

Every tenth person found eligible for Vocational Rehabilitation services is given the option of receiving services through the traditional system or through the choice project. In the project, participants are given complete control over their case services dollars with facilitation through a rehabilitation team approach. The project uses the existing Department of Vocational Rehabilitation purchase order system to pay for services selected by participants, each of whom has a budget of approximately $3,300, and may negotiate hours of service but not costs, which are set by the state. Consumers are also involved in empowerment training, peer supports, and incorporation of the choice philosophy within the broader Vocational Rehabilitation community.

Washington, D.C.

The United Cerebral Palsy Association in Washington, D.C., is operating a demonstration grant called "Project Choice Access" at three sites across the U.S. - Detroit, Pittsburgh, and New Orleans. Each of these three sites follows a supported employment model.

The project is focusing on traditionally underserved and unserved populations with significant disabilities, particularly those with minority backgrounds. Consumers use "choice cards," or vouchers, to purchase services and supports to achieve consumer-selected employment.

Consumers, with the assistance of the project coordinator, develop a personal future plan to clarify interests, needs, and identify natural supports. Consumers then select an employment facilitator (a form of a job coach) to assist in the development of an employment plan that includes a vocational profile, the type of job sought, and associated services needs. The facilitator also assists the consumer in selecting a vocational assessment provider and all other necessary services vendors.

Consumers who spend less than the project cost per consumer are eligible to receive an employment enhancement credit that they may use to purchase services needed to maintain employment. Financial incentives are also available to employment facilitators as a means to control projects costs.

Arizona

A voucher system and a purchase-order system for supplies are two primary features of the Southwest Business, Industry and Rehabilitation Association (SWBIRA) in Scottsdale, Arizona, which seeks to increase client involvement and decision making in the rehabilitation process.

Project staff work collaboratively with the Arizona State Rehabilitation Services Administration and local mental health agencies to identify potential consumers. A network of 50 service providers is being established to address a comprehensive array of rehabilitation needs.

SWBIRA has implemented a case-management based approach that emphasizes consumer-driven vocational plans and consumer selection of services and service providers. Project staff provide consumers with service provider handbooks that contain descriptive profiles of the available services to support their decision making. Consumers negotiate service costs with each vendor and purchase services through a voucher system.

California

The choice demonstration project of the Center for Independent Living in Berkeley, California, is specifically designed for individuals who traditionally have been underserved in the Vocational Rehabilitation process, including ethnic minorities and those with limited English skills who have significant disabilities. A key feature is a series of empowerment workshops to teach participants their rights under the Americans with Disabilities Act and other laws, build their self-esteem, and provide them with the tools and information they need to make informed choices.

The project staff uses a consumer directed planning process with assistance provided on an as needed basis from project staff and peer counselors available through the Center for Independent Living. Project staff investigate area service providers and are developing an automated directory of vendors to help consumers select providers; however, consumers are free to select any vendor in the area. A form of voucher system will be implemented to help area vendors identify the individual consumer, rather than the Center for Independent Living, as the customer.

Florida

The Development Team, Inc., of Jacksonville, Florida, is collaborating with the Berkeley (California) Center for Independent Living and the Independence Center of Northern Virginia to incorporate consumer choice into an empowerment-oriented group program model. This model focuses on peer group decision making as the chief mechanism through which increased choice in the rehabilitation process will be achieved.

Two centers for independent living are each conducting three group programs involving 30-36 consumers. Strategies to increase consumer control include self-assessment, group process, peer support, self-management, self-advocacy, and business involvement.

Project staff and consumers developed manuals to help guide the decision making process. Group discussions are facilitated by a leadership team manager and volunteer guest speakers from the business community.

Each group has a budget of $13,000 with which to purchase services, with the amount allocated to any one individual decided on through a peer review process. The staff render

payment to service providers according to the budget developed by the group.

After group training, consumers initiate job search activities and participate in a career club with their peers for an additional three months.

Michigan

Michigan currently has in Innovation and Expansion Grant with the Michigan Association of Centers for Independent Living (MACIL) known as the Partnerships for Choice Project (PFC). Their primary goal is to provide consumers with the skills they need to successfully take charge of their vocational future. This is another opportunity to increase the extent to which consumers are involved with their rehabilitation planning and procurement of services. It is designed to facilitate consumer involvement in the development of an Individualized Written Rehabilitation Plan with high potential for successful vocational outcomes.

A partnership was formed with the ten Centers for Independent Living in the state. An Independent Living Skills Specialist from each Center for Independent Living is teamed up with a vocational rehabilitation counselor and a consumer. The partnership recognizes the talents and expertise of each member.

The counselor may play several roles in the partnership depending on individual consumer needs and others who may be involved in the rehabilitation plan. The counselor may facilitate as a specialist in assessment, vocational information, accommodations, resources, and placement. The counselors may coordinate community resources and function as a problem solver. Since consumer needs will vary, the counselor must be flexible, creative, and knowledgeable in many related areas including the surrounding community.

Consumers will be exposed to an intensive 20 hour training and facilitation experience at the local Center for Independent Living. The Independent Living Specialist will work with the consumer to assist in the personal exploration necessary to develop vocational options and alternatives. Consumers will generate vocational options and investigate cost-benefit alternatives.

Consumers in the Partnerships for Choice project will participate in two training modules. The first will focus on skills necessary for successful vocational planning. The second will serve to increase skills in selecting services providers based on informed choice and rational decision making.

The modules focus on defining a true partnership and the roles and responsibilities of all parties involved. They also include self-esteem, self-efficacy, personal exploration, the meaning of work, and an employment plan of action.

At the end of each training module, the partners will have a joint meeting to validate and reaffirm the consumer's goals, progress, and satisfaction. It is projected that 100 consumers will have the opportunity to participate and evaluate this pilot program.

Other Models

Leadership training for consumers is another critical area currently being addressed. The National Institute of Mental Health has had a three year Leadership for Consumers Project that recognizes the importance of empowering mental health consumers. Their program focuses on self-esteem, leadership techniques, and advocacy roles.

For 1994, the Administration on Developmental Disabilities (ADD) announced a priority area to fund a project on Leadership Education and Development of Individuals with Disabilities and Their Families From Culturally Diverse Backgrounds. Under this priority area, the Administration on Developmental Disabilities will award demonstration grant funds on leadership for this special population. The lead initiative intends to target individuals with developmental disabilities and their families from culturally diverse backgrounds to enable them to impact services delivery and fully access the services they need. This priority area is also a very inclusive one meant to cover individuals and families of all ages. However, they are particularly interested in proposals that foster the leadership development of young adults (15-25 years of age).

The goal of this project is to strengthen the ability of individuals with developmental disabilities and their families from culturally diverse backgrounds to serve as leaders and advocates on critical issues in the developmental disabilities field in the nation and in their own communities.

Summary/Recommendations

There are numerous programs currently being implemented across the country in support of the vision of consumer empowerment, informed choice, partnership, and excellence in the rehabilitation process. To further ensure success in these critical areas, a thorough study and evaluation process with consumer involvement is warranted. The most effective techniques and program models that achieve consumer satisfaction must be shared with all rehabilitation professionals, consumers, advocates, and other partners in the rehabilitation process.

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Glossary

GLOSSARY

For purposes of this document, the terms below are defined as follows:

- **Accommodation** - The process of adjusting the physical, affective, or cognitive requirements of a situation to enable an individual with a disability to perform required tasks or behaviors (Michigan *Casework Operations Manual*, Item 5175).

- **Career Ladder** - Employment which is characterized by a path of advancement and upward mobility allowing individuals with a disability to realize their full potential. May be used interchangeably with "meaningful career" in this document.

- **Consumer** - An individual with a disability who seeks services from the vocational rehabilitation system. This person is a partner with the counselor in the rehabilitation process, and may be referred to in this document as the "client" or the "customer."

- **Counselor** - Means the rehabilitation counselor and any others who may have specialized assignments related to a portion of that role such as a case manager or job placement specialist. It also means the primary audience for which this document is intended.

- **Empowerment** - The result that occurs when the consumer exercises informed choice during the rehabilitation process and has responsibility for the decisions which arise from this process.

- **Informed Choice** - The act of choosing based on factual knowledge; in the context of vocational rehabilitation this means that consumers know about the available options and the implications of each for them personally, and, based on these facts, make choices that are consistent with the facts.

- **Partner** - A person associated with another or others in some activity of common interest wherein each has equal status.

- **Partnership** - The shared relationship between the consumer and the vocational rehabilitation counselor in which the consumer is a full and knowledgeable participant throughout the rehabilitation process.

- **Professional** - When used in this document, refers to the rehabilitation counselor; is sometimes described as the "rehabilitation professional."

Appendix A

Effective Consumer-Service Provider Interactions in Vocational Rehabilitation

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Effective Consumer-Service Provider Interactions in Vocational Rehabilitation

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Photo courtesy Thomas Czerlinsky

Introduction

Empowered consumerism has gained increasing emphasis as it becomes ever more important for consumers to be active partners and participants in the rehabilitation process (Chandler & Czerlinsky, 1992; Czerlinsky & Chandler, 1990). As pointed out by Czerlinsky, Chandler, and Moore (1991):

> *Largely as a result of increasing political activism by consumers, significant others, and advocates, rehabilitation is no longer a process that is "done to" consumers. Such groups are increasingly demanding that they and their significant others be active partners in the rehabilitation process, as well as active decision makers in activities that intricately affect them. This activism can be seen in the growth of consumer-run groups that focus on employment, support, housing, social interactions, and other needed benefits* (p. 2).

Figures from the 1990 U.S. Census show that 9 percent of the population has disabilities, and that these individuals are nine times more likely to have difficulty finding work. One in every 25 Americans has a need for some type of assistance to achieve employment. Labor market participation figures show that only 12.3 percent of individuals with severe disabilities are employed. Additionally, only 65 percent of those individuals who have less severe disabilities are employed, as compared to an 80 percent employment rate for individuals without disabilities. Two and one half times more individuals with disabilities are at the poverty level than any other group, with men and women with disabilities making $2,600 to $3,600 less, respectively, than their peers without disabilities (Condeluci, 1991). In addition, Frank & Kamlett (1985) have estimated that the direct costs and expenditures in the United States for mental health care *alone* in the 1980s was between $19.2 billion and $22 billion per year.

In rehabilitation, rather than focusing on individual pathology, there is a push for the individual to function in different roles within the community and to participate in full community life as spouse, parent, friend, neighbor, and wage earner (Hume & Marshall, 1980). Professionals subscribing to the principle of normalization

> *...held firm to the belief that persons with disabilities should live where they have the best opportunity to lead normal lives They further proposed that community settings, rather than segregated institutions, would provide the least restrictive environment for most people* (Prieve & DePoint 1987, p. 4).

Movement to community settings and frustration over inadequate services has led to a concurrent "self-determination" movement in which consumers are forming coalitions for advocacy and self-help. Consumers are beginning to participate in the selection and operation of their own service systems and the planning and design of rehabilitation programs. Nosek (1992) pointed out that:

> *People who have been rejected by the service system, judged "unfeasible" by vocational rehabilitation professionals...and excluded from participation in society by an inaccessible environment, rose up in protest and demanded the right to determine their own lifestyle. The fundamental tenet...is that consumers are the best judges of what they need and, therefore, have the right to determine their future* (p. 39).

This has led to a network of consumer groups at the local, state, and national levels (Chamberlain & Rogers, 1990; Chamberlain, Rogers & Sneed, 1989). "Consumerism" demands that the power to make eligibility and closure determinations "shift from the counselor and the system to the individual" (Nosek, 1992, p. 39). It is through the involvement and cooperation of consumers, their representatives, and service providers that significant efforts are being made to change the service provision for individuals with disabilities (Campbell, 1991).

Recent legislation, such as the 1992 Amendments to the Rehabilitation Act and the Americans with Disabilities Act (ADA), supports this movement and helps to ensure and protect the rights of individuals with disabilities. As so succinctly stated by Emener (1991):

> *The true value of rehabilitation services, even in the area of accountability, is not vested in the number of closures but in the impact on the quality of life and on the happiness of life of each individual client served* (p. 11).

The 1990s is the decade of empowerment for persons with disabilities (Carney, 1991; Nichols, 1990; Schmidt, 1991). Consumer goals and preferences and an individualized and flexible rehabilitation plan with a strong emphasis on work, housing, and social activities in the community have become "key ingredients for successful reintegration" (Carling, 1990).

While this philosophy has gained acceptance, even among reluctant rehabilitation service providers, very little attention has been paid to training the rehabilitation practitioner about the need for empowered rehabilitation partnerships, and how such partnerships can most effectively be established and maintained. While some experts have focused on the critical elements for creating an empowered rehabilitation partnership, empirically there is a lack of data. This study is one of the first empirically-based national investigations addressing empowerment as part of the rehabilitation process.

Methods and Results

Surveys and Participants: This study utilized a national sample in a three-stage modified nominal group approach. The participants included more than 300 service providers, political activists for individuals who have disabilities, rehabilitation policy makers, rehabilitation consumers, rehabilitation educators, administrators, significant others, and consumer activists.

The first survey asked respondents to identify, in a completely unstructured format, those elements that they considered to be critical for creating an empowered partnership. They were asked to respond regardless of the general acceptance of the element so that not only the general elements but also unique aspects for creating partnerships would be identified. All of the elements that were elicited on the survey in the first round of the study were treated as being of equal importance.

The second survey was designed to classify and rank, in terms of importance to the rehabilitation partnership, the original set of elements obtained in the first survey. The second survey also identified those empowerment elements that might be specific to particular individuals with certain types of disabilities.

The third and last survey required all participants in the study to identify a methodology or behavioral technique that would indicate the presence or absence of each individual empowerment element within an ongoing rehabilitation relationship.

The selection of participants for the project was initiated by conducting a random selection of individuals from the mailing lists of all major organizations dealing with rehabilitation. These lists included organizations focusing specifically on consumers of rehabilitation services, advocates, significant others, service providers, educators, administrators, and individuals involved in the political arena. All of the selected participants were mailed a packet that included the first open-ended survey. From this mailing approximately 300 responses were received. These open-ended responses were then subjected to Q-sort procedures. Q-sort procedures provide a method for taking unstructured data and identifying classifications and categories to bring order to the data. As a result of these procedures, six specific *categories* of empowerment elements were identified. These were: (1) Consumer Issues and Responsibilities; (2) Service Provider Characteristics; (3) Service Provider Roles; (4) Service Provision Techniques; (5) Qualitative Elements; and (6) Other Issues.

"Other Issues" is a category containing elements that could not specifically be classified under the first five categories but were considered important by the raters. There was extremely wide variation in the frequency of endorsement of each element as well as in the number of elements that ultimately fell under each category. The defined categories, and the elements that fell under each category, were utilized to construct the second survey. In total, under the six

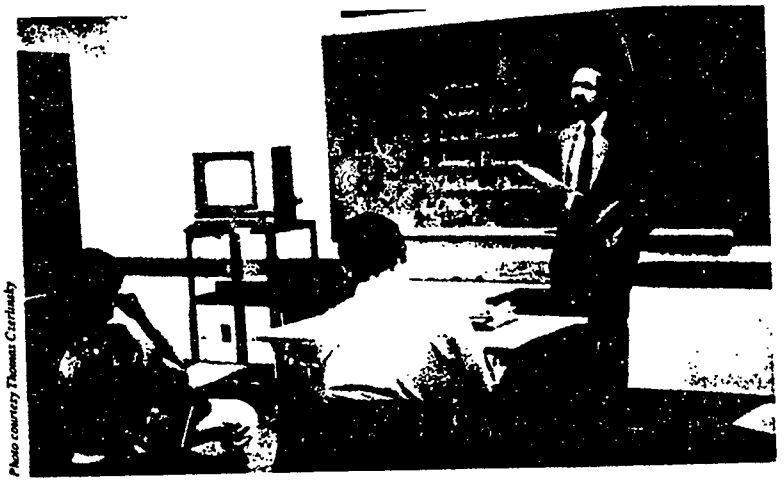

Photo courtesy Thomas Cuthusby

categories, 733 different and unique partnership building elements were identified by the respondents as being "critical to creating an empowerment relationship." The instructions to the participants were to consider each element in terms of importance to consumer empowerment, and then to rate each element on a 7-point Likert scale in terms of how important that element is to empowerment, with 0 being "Not At All Important" and 6 being "Extremely Critical." In the third survey, the instructions to the respondents were to consider each element and indicate how they could tell if that element was present or absent in terms of behavioral, quantifiable, or measurable characteristics. The authors are currently using these behavioral indicators to determine what empirical impact the inclusion of empowerment elements might have on consumers and rehabilitation professionals.

Results

(1) Consumer Issues and Responsibilities:

This category included a number of subcategories and elements that were rated as critical and statistically significant. Among these were:

- Consumer is responsible for actions and consequences:
  Accepting ownership of problems.
  Having a role in one's own rehabilitation process.
- Consumer is responsible for goals:
  Participating in one's own plan.
- Consumer is responsible for decision making:
  Being actively involved in the process.
  Having the service provider actively encourage decision making.
  Having input into one's own future.

Indications: The critical elements found for "Issues and Responsibilities" of consumers were very consistent. Overall, for a truly empowered partnership to be built and sustained, the environment within which the rehabilitation relationship occurs should be one which conveys to the consumer that he or she must be an active decision maker and partner within the process. In addition, it is the responsibility of the service provider to encourage the consumer to accept full responsibility for his or her own life. The implications are that the traditional service delivery model would be inappropriate for creating an environment that fosters an empowered relationship.

(2) Service Provider Characteristics:

The first category focused on elements that consumers must provide. The second category focused on service provider issues and characteristics. Under this category, subcategories were identified, with elements under each. The subcategories and elements found to be most critical were:

- Service provider knows and admits his or her limitations to the consumer:
  Realization that the service provide does not have all the answers.
  Awareness of personal and professional limitations.
  Willingness to be wrong and admit it.
  Willingness to confront in a nonjudgmental manner.
- Service provider has unconditional regard for the consumer:
  Accepts the consumer as a person.
- Service Provider is motivated:
  Listens to the consumer.
  Attends sessions regularly.
  Communicates an interest in the consumer.
- Service provider education and training issues:
  Upgrades level of knowledge regularly.

Indications: Those elements found to be statistically significant for "Service Provider Characteristics" fell into a number of distinct domains. First, service providers must be cognizant of their own limitations. This serves as a good role model for consumers in that they must learn that mistakes are common to all individuals. Related to this interpretation, service providers need to continuously upgrade and improve their professional skills and knowledge. Service providers must be motivated listeners who encourage consumers to be actively involved in their *own* rehabilitation process. Interestingly, the element "Regularly attending sessions" was rated as highly significant. Consumers are saying that they demand the same respect, in terms of attendance, that service providers expect of consumers. Clearly, these patterns show the mutual, two-way process that is required for an empowered rehabilitation partnership.

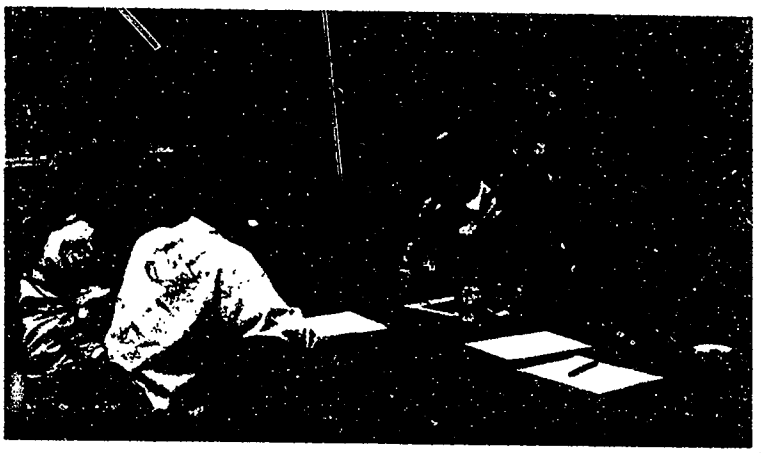

Photo by Thomas Carlisky

(3) Service Provider Roles:

In this category, the subcategories included self-disclosure, goal orientation, cultural and ethnic issues, encouraging the freedom of the consumer, and the service provider as educator. Across these subcategories, a number of elements were identified including:

- Avoid labeling the consumer.
- Recognize one's own biases.
- Allow the consumer to engage in self-exploration.

Indications: These major elements suggested that the critical roles service providers need to take in terms of an empowered partnership revolve around issues of consumer individuality. Service providers must accept consumers as individual, unique beings, and encourage this individuality within the rehabilitation process. Labeling and classification systems and practices, so common in traditional service delivery models, have no place in an empowered rehabilitation partnership.

(4) Service Provision Techniques:

This category focused on specific techniques in the rehabilitation process. This was the most comprehensive category and included a large number of subcategories and elements.

- Treat the consumer as an adult:
  Service provider addresses the consumer as an adult.
- Communication skills:
  Service provider communicates at a level appropriate for the consumer, speaking directly to the consumer. Service provider listens and encourages consumer involvement in the process. Service provider is an active, *empathic* listener.
- Emphasis placed on consumer's strengths:
  Help consumer to identify his or her strengths.
- Service provider respects consumer's values and beliefs:
  Belief in and respect for rights of the consumers.
- Rehabilitation/treatment as a partnership/team effort: Encourage consumer involvement.
  Is open to consumer's questions.

Indications: Two major themes emerged from this collection of empowerment elements. To create an empowered partnership, consumers must be treated as adults, whose beliefs and values are respected. The communication skills of the service providers must be attuned to the consumers. To foster and sustain independent decision-making activities by the consumer, the communication level must be appropriate and direct. Consumer input must be actively and emphatically sought for the direct communication process to be nurtured.

(5) Qualitative Elements:

Under this category, many traditional service provision elements were judged important, but there were also several unique empowerment elements.

- Respect:
  Service provider shows genuine respect to the consumer.
- Honesty and genuineness:
  Rehabilitation relationship is based on honesty from both sides.
  Service provider keeps commitments and promises.
  Service provider answers questions as accurately as possible.

Indications: The main themes under "Qualitative Elements" focused around the issues of respect, honesty, and genuineness. While these themes are certainly not new to a rehabilitation relationship, the results indicated that it is imperative for these qualities to be valued by *both* members of the rehabilitation partnership. The elements indicated that service providers *must* keep commitments and promises to consumers and must respond to consumer questions with honesty just as service providers expect the consumers to do the same.

(6) Other Issues:

This last category was a matter of concern to participants because the elements are not always present within the rehabilitation relationship. Thus, under "Other Issues," the following categories and specific elements were judged to be critically important:

- Confidentiality and ethics:
  Consumer has right to privacy.
  Service provider has a commitment to ethical practices.
  Sessions are taped only with permission.
  Confidentiality is ensured.
  Consumer is able to discuss fears regarding confidentiality.
  Service provider maintains professional manner.
  Service provider explains limits of confidentiality.
  Service provider maintains clear boundaries.

- Vocational issues:
  Consumer is an active participant in the job search.
- Follow-up issues:
  Service provider follows through on commitments.

Indications: Under this category, three major themes were identified as critical to an empowered rehabilitation partnership. The first focused on confidentiality and ethics. This theme was judged as extremely important by *both* consumers and service providers. The major element was that the consumer has the right to privacy. Both parties clearly felt that an empowered relationship requires that consumers have the right to keep certain parts of their lives to themselves, particularly those aspects not directly related to the purposes of the rehabilitation relationship. Clearly, both service providers and consumers have their own boundaries for the rehabilitation relationship, and these boundaries must not be violated if a partnership is to be built and sustained. Additionally, it is the responsibility of service providers to explain the purposes and boundaries of confidentiality issues as well as the possibility that outside sources, such as the legal or medical systems, may obtain records about the rehabilitation relationship. In terms of the job search process, the results showed that, as in all other aspects of the rehabilitation relationship, consumers must be active decision makers if the process is to succeed.

Summary

The inferences to be drawn from the results of this study have clear implications for creating an empowered partnership between consumers and service providers. The results provide recommendations about the effects empowered partnerships have on vocational outcomes and the quality of life of citizens with disabilities. Overall, the results show that the rehabilitation process for consumers must be a nurturing and empathetic one. It is not a short-term process. Importantly, consumers themselves must be actively included in all phases of the rehabilitation process, and their input must be actively sought. By becoming active participants in the rehabilitation process, consumers become proactive decision makers and learn to become self-directed and independent. Many individuals have long histories of "having things done to them," and of being the recipients of a service delivery model that often does not foster the self-respect and self-determination so essential for positive vocational outcomes and for an optimal quality of life. Many consumers immersed in the "system" have not had the opportunity to learn how to direct their own lives, making an empowered rehabilitation partnership difficult. It is, therefore, important that rehabilitation service providers create an environment, both physically and psychologically, that fosters empowerment.

At the conclusion of this project, several critical products will be produced. Included among those are: (1) *A Service Provider's Handbook to Consumer Involvement*; (2) *Active Involvement in Rehabilitation: A Guide for Rehabilitation Service Users*; and (3) Video tape training packages on *Consumer Involvement in Rehabilitation Partnerships*, and *Empowerment Issues for Rehabilitation Service Providers*.

On completion, this project will provide the essential information and models for rehabilitation service providers, consumers, and advocates to maximize involvement and decision making, and, thereby, to optimize the outcomes of the rehabilitation process for all parties.

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Appendix B

Empowerment Counseling
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REHAB BRIEF Bringing Research into Effective Focus

Vol. XVI, No. 6 (1994) ISSN: 0732-2623

EMPOWERMENT COUNSELING

CONSUMER-COUNSELOR PARTNERSHIPS IN THE REHABILITATION PROCESS

It used to be that rehabilitation was something "done" to a person. The idea was that it took a professional with training and a degree or certificate to discern what life course a person with a disability could or should be encouraged to take. Rehabilitation professionals were expected to develop the expertise to know what was possible, what was reasonable; their task was to inform people with disabilities about what they could do and help them do it.

Today the social climate has changed. Heightened awareness has led to a movement toward self-advocacy. Rehabilitation counseling consumers are now encouraged to be, and demand to be, active participants in the whole spectrum of rehabilitation services. "The fundamental tenet," says activist-psychologist Peg Nosek, "is that consumers are the best judges of what they need and, therefore, have the right to determine their future."

Legislation, Consumerism, and Empowerment

Federal disability legislation increasingly reflects growing understanding that all people need and have a right to make decisions about their own lives. Between 1916 and 1973, federal provisions established rehabilitation service models. Begun in response to the needs of wounded war veterans, these were largely professionally driven. The 1973 Rehabilitation Act, however, introduced the Individualized Written Rehabilitation Plan (IWRP), which required that consumers and counselors *jointly* create plans for reaching rehabilitation goals. Since 1973, political action has been based on a foundation of assumed consumer-counselor partnership.

- The 1978 Rehabilitation Act Amendments provided that individuals with disabilities be guaranteed more substantial involvement in the policies governing their rehabilitation.
- The 1986 Rehabilitation Act Amendments added support for individual consumer rights and revised the IWRP format to include consumers' statements of their own rehabilitation goals.
- The 1990 Americans With Disabilities Act furthered self-determination by consumers by ensuring rights in the areas of employment, transportation, public services, and public accommodations.
- The 1992 Amendments to the Rehabilitation Act further supported this movement toward self-determination.

Consumer empowerment has become the solid emphasis of today's rehabilitation policy and practice. During her tenure as Director of the Rehabilitation Services Administration, Nell Carney observed that "the 1990s is and will be a decade of empowerment for persons with disabilities."

HOW TO EMPOWER?

Increasingly we focus on consumer participation and decision making in rehabilitation counseling. How can rehabilitation counseling be carried out to ensure shared partnership? What makes for a consumer-empowering relationship in rehabilitation counseling? What are the critical counseling elements that lead to a balanced counselor/consumer partnership in the process of vocational rehabilitation?

Although consumer participation and active decision making are now commonly seen as positive goals, they have been studied very little. Several researchers have examined other aspects of effective counseling, but few have focused on the elements that directly promote consumer involvement and consumer/counselor partnership. As a result, little attention has been paid to training rehabilitation practitioners how to establish empowering partnerships and how to maintain them effectively.

Thomas Czerlinsky and Shirley Chandler conducted a 3-year project funded by the National Institute on Disability and Rehabilitation Research (NIDRR) to address these issues. They

- identified, classified, and evaluated elements of rehabilitation counseling relationships that relate to increasing consumer involvement and decision making in counseling relationships;
- developed alternative models of effective counseling, offering recommendations for maximizing consumer involvement; and
- developed a training package of print and videotaped materials for consumers and service providers, to enable both groups to become more effective partners in the rehabilitation process.

NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH • OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES • DEPARTMENT OF EDUCATION • WASHINGTON, D.C. 20202

Czerlinsky and Chandler surveyed a national sample of rehabilitation consumers and consumer activists, service providers, rehabilitation policymakers, rehabilitation educators, and administrators. During three rounds of questioning, more than 300 participants identified, classified, and ranked elements they considered vital for creating counseling partnerships that would be empowering to consumers.

ELEMENTS OF EMPOWERMENT

This *Rehab BRIEF* highlights six categories of elements that experts identified as being critical to creating empowering relationships.

1. Consumer Issues and Responsibilities

Elements that consumers bring to empowering consumer/counselor relationships include the following.

- Consumers take responsibility for their own actions and the consequences of their actions. This implies
  - accepting ownership of their problems,
  - taking the lead role in their own rehabilitation processes, and
  - overcoming learned helplessness.
- Consumers are responsible for decision making, implying
  - active involvement in all the processes,
  - providing choices, setting or redefining goals,
  - providing input into all future planning efforts.

Implications for Practitioners: For an empowering partnership to be built and sustained, the environment in which it occurs should convey to consumers that they are the responsible, active decision makers. They must realize that their futures are in their own hands. It is the responsibility of practitioners to help consumers assume full responsibility for their own lives.

2. Service Provider Characteristics

Service providers in empowering relationships show the following characteristics.

- Service providers know and admit their limitations. They
  - realize that they do not have all the answers,
  - are aware of personal and professional limitations,
  - are willing to be wrong and admit it, and
  - are open to constructive criticism.
- Service providers display unconditional positive regard for the consumers whom they serve. They
  - accept consumers as individual personalities, and
  - are willing to confront maladaptive ideas in ways that don't judge the consumers who express them.
- Service providers are motivated to
  - listen attentively to consumers' expressions of needs and desires,
  - attend sessions regularly,
  - communicate their interest to consumers, and
  - behave consistently in a competent manner.
- Service providers continually seek additional education and training to upgrade their levels of knowledge and expertise.

Implications for Practitioners: When rehabilitation practitioners make mistakes or do not have answers to consumers' questions, they must show willingness to learn from their own mistakes and information gaps. This aids their own growth and serves as good role modeling for consumers. Counselors need to seek regular opportunities to improve their skills, knowledge, and abilities as active listeners who encourage consumers to take charge of their own life processes.

3. Service Provider Roles

Critical roles that counselors play in the empowerment process include:

- working to gain understanding of the consumer's world,
- recognizing their own biases and striving to eliminate biased attitudes toward other cultural groups,
- developing sensitivity to multicultural issues, and
- avoiding the use of labels that stigmatize individuals.

Implications for Practitioners: Counselors are called upon to act in different ways at different times. It is critical to have the ability to change roles appropriately and to avoid such inappropriate roles as psychologist, psychiatrist, or physician. Czerlinsky and Chandler's findings suggest that empowering roles all focus on consumer uniqueness. Practitioners must be able to perceive each consumer's uniqueness and encourage all consumers to develop their own individuality within the rehabilitation process. Traditional disability labeling and classification have little place in empowering rehabilitation partnerships.

4. Service Provision Techniques

Specific counseling techniques that contribute to consumer empowerment include:

- treating all consumers as adults;
- using age-appropriate language and techniques;
- developing effective communication skills
  - tailoring communications to individual consumers,
  - speaking directly to consumers when another must be present,
  - encouraging client involvement at every step in the process,
  - listening empathetically;
- placing emphasis on consumers' strengths
  - helping to identify strength patterns,
  - focusing on abilities, while being realistic about disabilities or weak areas;
- respecting consumers' values and beliefs
  - providing accepting environments,
  - encouraging independent thinking and acting,
  - focusing on consumers' feelings,
  - respecting consumers' rights.

A different view of empowerment is presented in the following excerpt from ***Personality and Adversity: Psychospiritual Aspects of Rehabilitation***. In a section headed "From Wounded to Powerful," the author asserts:

"We humans have been as embarrassed about our power nature as our sexuality ... While a few people unabashedly amass all the power over others that they can, more claim neither to have it nor want it. People with power are urged to share it with those who feel powerless. The latter are told they have more power than they realize; they only need to acknowledge it and use it differently. CEOs are enjoined to empower middle managers who are exhorted to empower supervisors who are coached to empower mission workers; service providers are urged to empower consumers.

"The empowerment thus touted is largely a rectification, giving power back to individuals whose autonomy should never have been usurped in the first place. The state says, 'Don't *act* on your own. We'll tell you how to act and when to do so.' The church says, 'Don't *think* for yourselves; we'll tell you what you should believe.' Neither pays much attention to *feelings* so psychiatry says, 'We'll tell you which of your feelings are okay.' Societal institutions will continue to control our actions and thoughts and feelings until we learn to harmonize them inwardly to such a fine level of attunement that no one could convince us they know better than we do what is good for us or what is right.

"A little help along these lines might be empowering, but I'm less sure about the effects of what is popularly called 'empowerment.' The word has lost meaning through overuse and the different ideas intended, which range from the political to the transcendental. If we're not going to use different words for discrepant phenomena, use of modifying adjectives might help.

"Political empowerment and psychospiritual empowerment may represent polar categories. Political power is decision freedom gained laterally, from other humans operating on the physical plane. In general, it appears to be finite in amount; what one person gains is taken from or relinquished by another. Psychospiritual power is decision freedom gained vertically, from sources conceived as existing above the level of ordinary physical human existence or from our depths. Most ontological doctrines say this kind is infinite; if it isn't, the pool is so large that the point is moot.

"The empowerment that service providers are encouraged to pass on to consumers is generally political, not spiritual. It is rectifying—the return of power which helping professions should not have taken from 'patients' and 'clients'; we 'empower' in the sense of ceasing to hinder. Ambivalence arises whenever political power is shifted. We want people to take the bite of life into their own teeth—right up to the point at which it seems that they will *make mistakes* if they don't do what we recommend. Or when they feel empowered to act in ways that make waves on the surface of bureaucratic calm, we may tend to pull back. We want to be proactive, not reactive, but are less comfortable when service consumers want that, too.

"Most of us could go further than making amends and genuinely facilitate others' *self empowerment*—that is, becoming aware of, receptive to, and in charge of using psychospiritual power they already possess. The psychological aspect may be referred to as 'motivation' or 'self confidence.' The spiritual aspect is sometimes called 'Grace' ....

"Practitioners can 'empower' people ... by getting obstacles out of their way, staying out of their way themselves, facilitating self-empowerment, and occasionally by providing inspiration through the attitudes or behavior they model in conducting their own lives ... A few healers and shamans, past and present, appear able to directly empower others, but such goals exceed the scope of this book."

Implications for Practitioners: To create an empowering partnership, practitioners must regard consumers as equals whose values are as valid as theirs. Communication skills must be attuned to consumers' needs. To foster and help sustain independent decision making, practitioners must be direct in their communications and actively encourage consumer inputs.

5. Qualitative Elements

The main themes in this category are mutual respect, honesty, and genuineness.

- Respect
  - Behave respectfully to consumers.
  - Keep any commitments or promises made.
- Honesty and genuineness
  - Show and expect honesty.
  - Be genuine.
  - Answer questions as accurately as possible.

Implications for Practitioners: These themes are not new in rehabilitation, but the Czerlinsky and Chandler findings suggest that they are important values for *both* rehabilitation partners. Practitioners must honor commitments, and consumers must be honest with practitioners in order to benefit from the relationship.

6. Other Issues

Among a variety of other elements, the most important ones for establishing an attitude of partnership relate to confidentiality and ethics. The researchers' advice to practitioners is straightfoward.

- Permit yourself no lapses from consumers' rights to privacy.
- Tape sessions only with permission.
- Ensure confidentiality of consumer disclosures.
- Make it safe for consumers to discuss any fears they may feel about confidentiality.
- Explain the legal limits of confidentiality.
- Make a commitment to following the highest standards of ethical practice.
- Maintain clear boundaries between friendliness in a service relationship and personal friendships.

Implications for Practitioners: Confidentiality and ethics are judged to be extremely important by both consumers and service providers. Consumers have the right to keep aspects of their lives that are not directly related to the purposes of the rehabilitation to themselves. Practitioners and consumers both have legitimate boundaries. It is important to clarify the possibility that outside entities, such as legal or medical systems, may obtain records about the rehabilitation relationship.

REVIEWER COMMENT

The most empowering relationships I have had with rehabilitation counselors have been ones in which I explained my goals and they facilitated my achieving them. The two with whom I had this were highly evolved people who had no need to feel superior to me. I'd add "be each other as equals" to the guideline list.

Being respectful is important, but being challenging is equally important. It's nice to make people feel good, but it's very hard out there. A basic mistake made by counselors is playing into learned helplessness by failing to help clients toughen up, get the basic skills they need. It's a sort of "tough love" issue ... playing devil's advocate to make sure the person gets through boot camp strong enough to compete. There's nothing disrespectful about this; counselors had to go through it themselves; there's no shame in it.

It's important also to avoid accidental disempowerment. Service providers must be continually educated regarding work disincentives so they don't lead clients into red tape traps or lead someone off a cliff. They're teaching people who are in perilous situations, where they could lose their homes, but I've known counselors to suggest things that showed no realistic understanding of what could happen.

Nancy Becker Kennedy, Actor

THE PRACTITIONER'S ROLE

Counselors and consumers may have different goals in counseling. Counselors may be constrained by agency rules or values that conflict with consumer's desires for goal achievement. Consumers may enter with apprehension and lack of trust.

Activist-sociologist Irving K. Zola and others have pointed out that while changes in attitude and behavior have to occur in both counselors and consumers, *the greater adjustment is made by counselors.* Because counseling interventions can help consumers become more active participants, *counselors must serve as agents of change initially.*

Counselors must initiate mutual respect. Once mutual respect is established, consumers and providers together set the tone for consumer independence. Consumers who sense honesty in counselors are more likely to offer honesty in counseling relationships.

As a result of such two-way communication, consumers can define their own needs and goals clearly. Counselors facilitate this by listening openly, nonjudgmentally, and without bias

Strategies That Promote Successful Consumer/ Counselor Partnerships

- *Assessment must be comprehensive and individual* so that counselors can understand consumers' needs, wants, skills, and weaknesses. Deep awareness of individuality is critical to the success of empowering relationships.
- *Consumers' strengths play a major role in their empowerment.* If consumers don't see that they have strengths on which to capitalize, counselors must help them to recognize their own capabilities and to see ways to work around their impediments.
- Consumers' disabilities affect their families, spouses, friends, and other individuals who can be assets to counseling and its outcomes. In the past, many rehabilitation professionals underutilized these valuable resources. *Involving "significant others" (with consumer consent) in counseling can be a critical element in creating empowering relationships.*
- *Follow-along services that are not intrusive but continue to support empowerment can be critical for achieving desired long-term outcomes.* Counselors should recognize that consumers may choose to discontinue at any time. Counselors should not foster dependency; too much followup may be seen by consumers as lack of confidence. An empowered consumer will probably feel free to reinitiate service contacts if the need arises.
- Once consumers leave counseling, their success may depend on their abilities to access community resources. Counselors can enhance consumers' self-reliance by teaching them how to get information and tap into supportive workplace and community networks. *Consumers who discover community-based resources can be more independent and transfer their personal empowerment beyond the counseling arena into all realms of life.*

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We welcome your comments on this BRIEF and on BRIEFs put out during the past year, as well as your suggestions for topics and for improving this publication of Conwal Incorporated

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END

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Date Filmed
March 23, 1996

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