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ABSTRACT

This document presents five action papers and three invited papers originally presented at a seminar concerned with accountability in rehabilitation. Each of the five principal chapters contains three parts: an action paper, selected scholars' reaction papers (brief written responses to the action papers), and the summary of recommendations which resulted from small group discussion about the paper. The action papers are: (1) "Responsibilities of People with Disabilities" (Carolyn Vash) and reaction papers by Norman G. DeLisle, Jr., Donald E. Galvin, and Beth Robertson; (2) "Practitioner Accountability: Professional, Credentials, and Regulations" (Michael Leahy) and reaction papers by Donald J. Dew, Bruce G. Flynn, and Jan Skinner; (3) "Accreditation as an Accountability Strategy" (Donald Galvin) and reaction papers by Craig L. Feldbaum, Brian Fitzgibbons, and Kimberly Turner; (4) "Vocational Rehabilitation and Cultural Competence: Considering Accountability" (James Mason) and reaction papers by Eddie E. Glenn, Kevin F. Manning, and Peggy Rosser; and (5) "Research: Areas of Accountability Issues" (John Westbrook) and reaction papers by Norman G. DeLisle, Jr., Craig L. Feldbaum, and Peggy Rosser. The special invited papers are: first, "Bio-models of Diverse Communities" (Norman G. DeLisle, Jr.); second, "Impact of the Workforce Investment Act on Accountability in the Vocational Rehabilitation Services Program" (Harold Kay); and third, "Accountability and the 1998 Rehabilitation Act Amendments" (Thomas G. Stewart). (Individual papers contain references.) (DB)

Accountability from Several Perspectives

A Report on the 20th Mary E. Switzer Memorial Seminar

Seminar held: September 1998

Edited by
L. Robert McConnell, D.P.A.

National Rehabilitation Association

Tribute to Mary Switzer

The Switzer Seminars and Monograph series are named as an on-going tribute to Mary Switzer, a pioneer and visionary leader in Rehabilitation. The people who knew her remembered her for her compassion and foresight. She became director of the Federal Office of Vocational Rehabilitation in 1950 and was instrumental in the shaping of Public Law 565, the 1954 Vocational Rehabilitation Act Amendments. This legislation is most noted for its expansion of services to persons with mental impairments, its establishment of demonstration grants, the initiation of rehabilitation facility grants and the authorization of funding to colleges and universities for the training of professional rehabilitation workers.

Ms. Switzer served as Commissioner until 1967, when she became the first Administrator for Social and Rehabilitation Services, serving until 1969. In addition, she was Vice President of the World Rehabilitation Fund until her death in 1971, and had been a President of N.R.A. in 1960-1961.

She was fondly remembered and recognized in the November/December 1971 issue of the Journal of Rehabilitation: "While readily recognized as a truly great administrator in the classical sense, her true capacity and ability can only be appreciated when we realize that these accomplishments sprang from an inner expression of sensitivity, emotional refinement and dedication to serve all less fortunate people. Her egalitarian qualities were not contrived but spontaneous, stemming from love and respect for all living things."

It is significant to note that two of this year's Switzer authors cite Mary Switzer as directly or indirectly responsible for program advances in the areas of Accreditation and Counselor certification respectively. Mary Switzer has left a legacy of courage, caring, and innovation from which all of us benefit.

A Special Tribute to Len Perlman: "Mr Switzer Seminars"

It is difficult to envision the Switzer Seminars and monograph series without Dr. Len Perlman. For twenty years, and 19 seminars, beginning in 1976, Len has held the title of coordinator/consultant. He has been, until this seminar, the only coordinator the program has ever had. Originally approached by Betty Hedgeman – herself a former NRA president and past Switzer scholar from New York – for a one year consultant contract for this new program, Len's agreement was renewed 18 times. In that span of years, he brought together some 380 scholars and produced 19 monographs on subjects ranging from the first seminar on "Pathology, Impairment, Functional Limitation and Disability - Implications for Practice research, and Program Develop", to his 19th Seminar on "The Entrepreneur with a Disability".

There is an extreme debt of gratitude each of us in the disability and rehabilitation community owes Len for the existence of this highly successful, highly prestigious program of NRA The title of Coordinator fails to capture the extent of his involvement for nineteen Switzer cycles. He was responsible for designing the format, communicating with the scholars, planning the sessions, preparing the materials, designing, editing and preparing the monograph for print, coordinating its distribution, and of course, raising funds through annual sponsors to assure the continuation of the program. To say that the program would not have existed these 20 years without Len is not an overstatement. Those of us who were fortunate enough to become Switzer scholars remember Len as the person who answered our questions, kept us on track, responded to our needs, "reminded" us of our due dates, and made us all feel very important.

Len's commitment and involvement with rehabilitation extend well beyond the Switzer program. He has been a member of NRA since 1961, having been most active with the National Rehabilitation Counseling Association (NRCA) division. He holds a Doctorate in Rehabilitation Counseling and Psychology from Penn State University, is a licensed psychologist and a certified Rehabilitation Counselor. He has worked in the field since 1961 as a state V.R. Counselor, a Jewish Vocational Services. Facilities' psychologist, and a consultant or supervisor in such areas as mental health,

addiction and epilepsy. Since 1976, Len has been self employed as a consultant in rehabilitation and disability with his clients including the Social Security Administration, The Rehabilitation Services Administration, the National Institute on Mental Health and many private organizations. Since his "retirement" from the Switzer in 1996, he remains extremely active with his other consultant customers and NRA affiliation. Thank you Len for your 20 years of distinguished service to the Switzer program. You certainly succeeded in accomplishing your goal "to operate a program as envisioned by the planners," which you felt "addressed cutting edge issues and served as a stimulus for further study and action in the rehabilitation community".

Good luck Len and keep in touch!

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Kim Turner, M.Ed.
Carolyn Vash, Ph.D.
John Westbrook, Ph.D.

The *Switzer Monograph* reflects the writings, discussions and recommendations of the Switzer Scholars at the 20th Annual Mary Switzer Memorial Seminar, held Sept. 24-26, 1998, at Michigan State University in East Lansing, Michigan. Opinions expressed in the *Switzer Monograph* are those of the writers and do not necessarily reflect policy of the National Rehabilitation Association or any other organization.

The National Rehabilitation Association is a non-profit organization dedicated to improving the quality of life for people with disabilities.

Published April 1999. To order previous editions of the *Switzer Monograph*, contact the National Rehabilitation Association at (703) 836-0850 or visit our web site at www.nationalrehab.org

Accountability from Several Perspectives

Chapters

Chapters

Special Invited Papers

Welcome

Linda R. Winslow
President
National Rehabilitation Association

The Mary Switzer Memorial Seminar coordinated by Dr. L. Robert McConnell, chose "Accountability from Several Perspectives" as the topic for its 20th year. In this fast paced changing environment, rehabilitation professionals have a responsibility to themselves, to individuals with disabilities, to vendors and other service providers as well as to the public to be accountable - responsible for actions taken. Using our resources for their maximum benefit to those we serve is required of us all.

NRA Past President Bettie Shaw-Henderson recognized the value of this prestigious seminar, co-hosted by NRA and the Michigan State University Office of Rehabilitation and Disability Studies and was successful in accomplishing its reinstatement. The contribution to the rehabilitation profession of the Switzer Seminar is invaluable. The Switzer Scholars continue to demonstrate excellence in their fields and we are most appreciative of their willingness to share their expertise. Through the efforts of many supporters and under the expert leadership of Dr. Robert McConnell all sectors of rehabilitation will benefit from "Accountability, from Several Perspectives."

Bettie Shaw-Henderson
Past-President
National Rehabilitation Association

The theme of the 1998 Mary Switzer Seminar, Accountability from Several Perspectives is very fitting given the current challenges facing the field of vocational rehabilitation.

As I look back, this past year has been a year full of magical accomplishments with the passage of the Rehabilitation Act Amendments of 1998 as part of the Workforce Investment Act of 1998, thus amending and extending for five years the authorization of the Rehabilitation Act of 1973. As we look forward, however, we must work to keep the values and principles alive that we have worked so hard to achieve. One area that must continue to be at the forefront is that of accountability.

We must work to ensure that all rehabilitation practitioners continue to be drivers in control of establishing and practicing standards that are relevant to their area of expertise and do not encumber their ability to provide the best and highest quality service delivery systems available. In addition, we must provide members with support to create and establish new systems that meet the work needs of the 21st century. We must always work to operationalize the principles and values set forth in the Rehabilitation Act, keeping the focus on the consumers whom we are serving. As customer focused service delivery systems insure our accountability at all levels and allow us to dream and create new ways of administering services while maintaining the highest professional standards. It is important that we maintain consistency -- for through our strength together, we can invoke more accountability in the field of vocational rehabilitation.

The Mary Switzer Seminar, a driving force in the field of rehabilitation, has allowed us the opportunity to realize Mary Switzer's dream of empowering persons with disabilities. We extend our profound appreciation to this year's Switzer scholars and to Drs. Hansen and Perlman, and Dr. Bob McConnell for their diligent and dedicated leadership in helping to maintain excellence in the field of rehabilitation.

1998 marked the resurgence of a vital tool in the advancement of the vocational rehabilitation profession – the Mary Switzer Memorial Seminar. After a three-year hiatus, Dr. L. Robert McConnell breathed new life into a Seminar dedicated to ensuring best practices in our journey to make self-sufficiency a reality for persons with disabilities.

The 20th Annual Mary Switzer Memorial Seminar Scholars focussed on the issue of accountability within rehabilitation delivery systems. One of the Seminar's greatest strengths is the breadth, depth and diversity of its Scholars allowing the most comprehensive analysis of an issue possible; 1998's Scholars were no exception. This monograph of their works outlines all of the issues pertaining to accountability - those systems that are working well and those systems needing some improvement. Only in an environment where all of the pertinent information is shared can a successful solution be developed. No one tool could be more powerful in our efforts to achieve excellence in the area of accountability than this publication.

We are sincerely grateful to Dr. McConnell and the 1998 Switzer Scholars. Their contributions to the profession of vocational rehabilitation are far reaching, their contributions to enhancing the lives of persons with disabilities are incalculable.

Michelle A. Vaughan

Michelle A. Vaughan
Executive Director
National Rehabilitation Association

The Switzer Seminar Scholars

Photo courtesy of Dr. L. Robert McConnell

Seated: Carolyn Vash. First Row (L-R): Beth Robertson, Jan Skinner, Eddie Glen, Kim Turner, Peggy Rosser, Thomas Stewart and Geraldine Hansen. Second Row: Norm Delisle, Craig Feldbaum, Harold Kay, Bruce Flynn, Kevin Manning and Brian Fitzgibbons. Third Row: Donald Galvin, Donald Dew, Carl Hansen, James Mason, John Westbrook, L. Robert McConnell and Michael Leahy.

The Switzer Seminars and Monograph Series has established a proud tradition of honoring distinguished persons in the rehabilitation community and promoting meaningful idea exchange on a subject of current importance in our field. We are pleased to offer the proceedings of our 20th Mary Switzer Memorial Seminar, entitled "Accountability from several perspectives". The common thread of accountability runs through each of the five action papers. Beyond that point, the similarity ends, each author brings their uniqueness in writing style, approach, content and conclusions to their papers. That is the richness of this process, each paper will inform and stimulate you differently.

We've introduced some changes in this publication that we hope will bring forth more of the content and richness of the seminar and better acquaint the reader with the scholars.

To the photographs and titles of the 19 scholars who participated, we have added a brief biographical sketch. Very little editing has been done, as we've chosen to have them describe themselves in the way that they have chosen to be. Hopefully, this will assist you the reader in better understanding who the members of the1998 Distinguished Class of Switzer Scholars really are.

The core of the document is the five action papers and reactions to them. Each of the five principle chapters contain three parts: the author's action paper, the summary of recommendations and implications, and selected scholars' reaction papers. The summary of implications and recommendations represent the product of the total group dialogue and a small group (4 - 5 scholars) discussion which took place the second and third day of the seminar about the particular action paper. This section is a new addition to the monograph and captures some of the ideas generated by the original action paper. The reaction papers are brief written responses to each of the five action papers which were developed in advance of the seminar by the scholars. We've included reaction papers from three or four of the scholars as a part of each chapter. Some of these papers may mirror your own perceptions, while others may stimulate new ideas in their own right. This is the first time we've included the full text of reaction papers. In the past, we've only cited excerpts.

We've also included three special papers. These are invited papers from some of this year's scholars. Special papers occur when a scholar has a particular area of expertise, a unique perspective or an area of interest that is germane to the primary seminar topic. We have used the occasion of the passage of new rehabilitation act legislation in 1998 to comment on the accountability aspects for two of these special papers.

We invite your participation and comments: This year we expanded the opportunities for reviewing and commenting on the papers. All five papers (and other Switzer information) can currently be accessed on our Website: **www.mswitzer.org**. Individuals can also sign up for a list serve whereby they can share and receive comments on the Switzer papers. "We invite your participation and comments."

Words from Chairperson of the Switzer Memorial Seminar - Carl E. Hansen

Accountability is often defined as, "being responsible or liable." It is also defined as, "to give reasons and/or to explain." I can think of no better topic for the 20th anniversary of the Mary E. Switzer Memorial Seminars. This year the focus was on accountability as it pertains to a broad range of perspectives. These viewpoints were written by nationally known authors and are contained within the body of this monograph. The papers dealt with the responsibilities of people with disabilities, accreditation, cultural competence, research and professional credentials. In additional to these five major papers, there was also a special presentation dealing with the 1998 Rehabilitation Act Amendments and accountability related to those amendments.

The Switzer Seminars were established in 1975 and have developed monographs dealing with a wide range of professional topics. These topics have dealt with rehabilitation of blind persons, rehabilitation of the mentally ill, technology, the aging workforce, private sector rehabilitation, the entrepreneur with a disability and so forth. These topics have been chosen over the years to reflect issues that were of professional concern to persons in the broad field of rehabilitation. The topic of accountability was developed under the guidance of Dr. L. Robert McConnell, Switzer Coordinator in cooperation with an advisory committee. The committee set in motion the topic of account-

ability in the Spring of 1998. The authors and scholars were selected shortly thereafter. The actual conference took place September 24 through September 26, 1998 at the Kellogg Center of Michigan State University.

Michigan State University played a pivotal role in facilitating this particular conference. In personal communication to me from Dr. Peter McPherson, President of Michigan State University, he indicated that the University is committed to the integration of learning, research and outreach. The Kellogg Conference Center was made available to us through the dedicated effort of Dean Ames of the College of Education and Professor Mike Leahy of the Rehabilitation Counselor Education Program. The conference was facilitated by the professional atmosphere within a comfortable location located on a major university campus.

The seminars are an outgrowth of the National Rehabilitation Association desiring to establish a program in honor of Mary E. Switzer. In 1971, E.B. Whitten, then Executive Director of the National Rehabilitation Association, eloquently summarized the contributions Mary E. Switzer made to the field of vocational rehabilitation. In his article printed in the Journal of Rehabilitation, November/December 1971, he pointed out that Mary E. Switzer became Director of the Office of Vocational Rehabilitation in 1950. She was primarily responsible for the passage of Public Law 565 with its research and demonstration features, concern for rehabilitation education, increasing rehabilitation facilities, expanding international efforts and providing a greater funding base for the State Vocational Rehabilitation Program. Her life was dedicated to governmental leadership on behalf of both disabled and disadvantaged persons. Were it not for the leadership of Mary E. Switzer whose life spanned from 1900 to 1971, the field of rehabilitation would not be at its current level of professional integrity and visibility.

The Switzer Seminars have historically been set-up to develop a monograph that will be broadly disseminated to practitioners, educators, researchers, writers and politicians. The procedure is to select five nationally known individuals to develop a written paper on a specific topic. In this instance, the overall topic dealt with accountability. Each author then developed content specific to their principal area of professional con- d related issues of accountability. For example,

CARL HANSEN

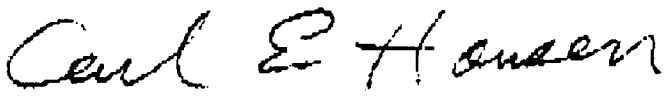
Carl Hansen has been in the field of vocational rehabilitation since 1965 after he received his Master's Degree from the University of Northern Colorado. After working for the California Department of Rehabilitation, he returned to the University of Northern Colorado and completed his doctoral degree. He served as a professor with the University of Texas at Austin for 26 years with most of those years in the position of Director of the Vocational Rehabilitation Counselor Education Program. Upon his retirement in 1994, he continued to operate his private business known as Vocational Appraisal and Planning. This is a counseling and forensic rehabilitation program that was established in 1975. Dr. Hansen served as President of the National Rehabilitation Counseling Association in 1974 and President of the National Rehabilitation Association in 1978. He continues on a number of local and national boards related to vocational rehabilitation as well as one financial institution.

accountability as it pertains to accreditation of rehabilitation facilities throughout the United States. Accountability as it pertains to the training of professional rehabilitation counselors. Accountability as it pertains to cultural competence. Accountability as it pertains to research. Accountability as it pertains to the person with a disability. These papers were reviewed by all scholars and individual presentations were then made by the various authors. A period of time was allowed to discuss, dissect, and absorb the information presented by the author of the paper. Near the end of the conference, small groups develop specific responses and proposals as related to the five topical papers presented. The result is found within the current publication and represents the 20th Mary E. Switzer Memorial Seminar.

The scholars that participated in this seminar were diverse and representative of state rehabilitation agencies, facilities, rehabilitation counselor education, research program, disability management and so forth. The makeup of the scholars was diverse yet significant unity existed within the comments and direction of recommendations. As chairman of the group, I found these participants to be like scholars found in the last

eight seminars that I have conducted; dedicated, professional, and willing to work in harmony toward the specific goal of creating a document useable to the professional society of rehabilitation.

The 20th seminar could not have been conducted without the historical precedence of Dr. Leonard G. Perlman. Dr. Perlman served as coordinator for the first 19 seminars and it was through his tremendous effort that these seminars have continued. Dr. Perlman is still active in his work as a psychologist in the broad field of vocational rehabilitation and is still contributing suggestions and orientation to the Switzer program. His effort is well recognized throughout the field of rehabilitation and it is with great appreciation that we honor Dr. Perlman's effort of 19 years with the 20th publication dedicated to accountability. He more than anyone else is accountable for the success of the Switzer Memorial Seminars.



Carl E. Hanseon
Chairperson
20th Switzer Memorial Seminar

"The horizons ahead where rehabilitation can be cutting edges of progress are broad and golden. There is no limit to the groups of people who can be assisted and served by this program. The limit lies only in the need for knowledge to deal with the unsolved problems. We are still lacking an organized approach in many areas which we must have before we can follow the road so successfully cleared by the rehabilitation leaders of the past."

Mary E. Switzer

(from a commemorative paper marking the 50th Anniversary of the Vocational Rehabilitation Act in the U.S., *Journal of Rehabilitation*, September, 1970)

Acknowledgements

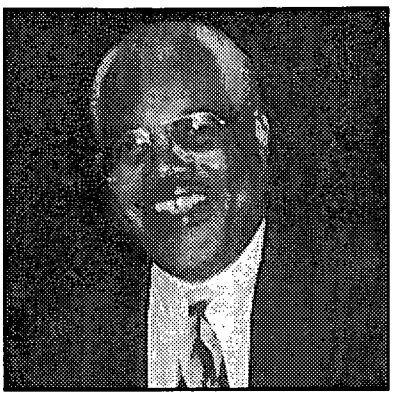
It takes a lot of talented and conscientious professionals to make the Switzer Seminar and Monograph series work. I am grateful to those persons and organizations who shared their knowledge, time and resources to make our 20th Seminar a success.

First to Dr. Len Perlman, my predecessor as the Switzer Coordinator for some twenty years. Thanks for your wise counsel as I pulled this seminar together, and for the sound model you have put in place. I have a better appreciation for the work involved in planning, coordinating, fundraising and follow-up in order to make the system work. NRA and the many scholars (350+) who benefitted from this program over the years owe you an extreme debt of gratitude.

Much appreciation to Dr. Carl Hansen, the master facilitator and Switzer Chairperson. You too are a veteran of some 10 years who does his job so well. Thanks for staying on to help me through my inaugural year. Your commitment to this project is evident by the donation of your time and continuing financial contribution to the Switzer Memorial Fund.

The success of this year's Seminar is due in a very large part to two friends and colleagues, Dr. Donald E. Galvin and Dr. Michael Leahy; both of whom performed triple duty. Each were part of the Planning Committee to design this year's topic, each were contributors of major action papers, and each were responsible for significant contributions to the Switzer Memorial Fund. Your gifts of "time, talents and treasurers" are very much appreciated.

A sincere note of thanks to my major partners in this venture: Michigan State University (M.S.U.) and the National Rehabilitation Association (NRA). The faculty and staff of M.S.U. Office of Rehabilitation and Disability Studies are acknowledged for their input, assistance and support throughout the process. As the host site, M.S.U. not only helped with coordination and planning, but also served as one of this year's sponsors. They were also the architects of our new Website.



The NRA Executive Director, Michelle Vaughn, and her staff are invaluable to this process. They have been most helpful from their management of the Switzer Fund, to publicizing of the Seminar, to publication of the monograph and much more. As a newcomer to this process, I have appreciated their dependability and willing assistance. I am also grateful for the strong personal and organization support provided by NRA past presidents Fitzgibbons and Shaw-Henderson.

An acknowledgment and a commercial for our sponsors. The Switzer series could not happen without them. Please take time to read the list of Sponsors, and if you see them thank them for making this 20th seminar and publication possible.

A final note of thanks to the five M.S.U. Rehabilitation Counseling Doctoral Students who volunteered their time to provide on-site preparation and assistance throughout the three day seminar. Their tasks ranged from photocopying to facilitating small group discussions. They were a critical part of the host site team. Thank you to Darlene Groomes, Andy Premister, Frances Saroki, Margaret Sebastian and Virginia Thielsen.

Special thanks for the administrative support services provided by Alberta Morrell, who produced much, many times within some very demanding time frames.

L. Robert McConnell
Editor
20th Switzer Monograph

20th Mary E. Switzer Memorial Seminar and Monograph

The National Rehabilitation Association, Mary Switzer Memorial Fund is indebted to the following organizations and persons whose financial support made possible the twentieth seminar and monograph publication:

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CARF -- The Rehabilitation Accreditation Commission

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Michigan State University - College of Education and Office of Rehabilitation and Disability Studies

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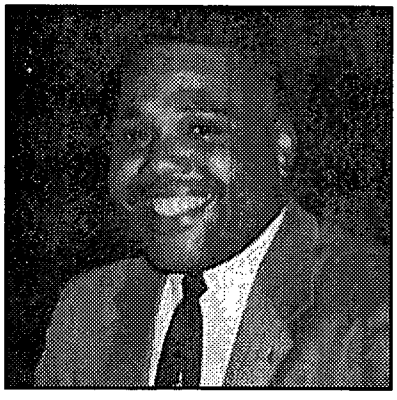
Norm Delisle

Norm Delisle has been a part of, and has worked with, Michigan's disability community all his adult life. His educational background is in psychology with graduate work in developmental learning and Montessori. He has worked in a wide variety of settings from school systems to medical programs and legal services, always with a focus on the broad community of people with disabilities, and their long quest for self-determination and community inclusion.

Norm has learned from personal experience what it is like to be dis-empowered, and cut off from the support of friends and family. He believes that the true role of professional knowledge is to effectively catalyze the deepest hopes and dreams of all people. Human services systems are at their best for both consumer and provider when they do not forget this basic goal.



Donald J. Dew, MSW

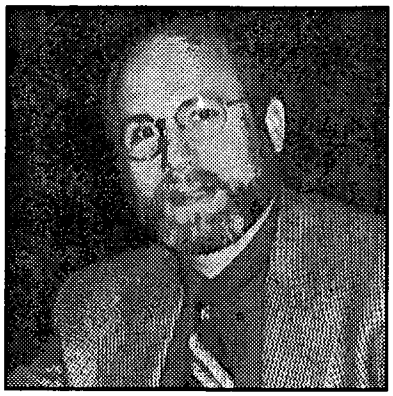
Since June 1990, Donald J. Dew has held the position of President/Chief Executive Officer of Habilitative Systems, Inc. (HSI), a human services organization serving Chicago's west side. HSI. currently operates some 60 employability development and related programs for the disadvantaged ersons with disabilities that has a budget in excess of $13.5 million dollars.

Mr. Dew, a westside native, has been employed at Habilitative Systems, Inc. since 1984 in varying positions including, Director of Case Coordination/ Management and Director of Vocational Services. He has been described as a "41 year old dynamo" in the unheralded field of social services.

Dew received his Master of Social Work (M.S.W.) degree in 1980 from Jane Addams College of Social Work at the University of Illinois (U.O.I.). He was a 1991-1992 Fellow in the Leadership Greater Chicago Program and earned his Certification in Business Administration from the U.O.I. in 1992. Currently, Mr. Dew is enrolled in the Ph.D. program at the University of Illinois-Chicago. Prior to employment with Habilitative Systems, Inc., Dew's social work experiences also includes work in the Juvenile Court of Cook County from 1978-1979, at the Westside Veterans Administration Hospital from 1979 to 1980, at Miles Square Health Center, Inc. from 1980 to 1982, at the Community Mental Health Council from 1982 to 1984, and also served as a consultant for the Institute of Community Health during the same period.

He is the recipient of the award for outstanding Young Men in America in 1984, the 1991 Community Service Award presented by the Community Mental Health Council, Inc., and the 1993 Positive Self Image Award presented by the Westside Center of Truth. Mr. Dew is also a Certified Social Worker (CSW) with the State of Illinois Department of Registration and registered Surveyor for the Commission on Accreditation of Rehabilitation Facilities (CARF) in 1989.

Donald J. Dew is a member of the National Board of Trustees, CARF, Schwab Rehabilitation and Care Network and numerous professional/civic organizations, including Omega Psi Phi Fraternity, Inc.



Craig L. Feldbaum, Ph.D., CRC

Craig L. Feldbaum, Ph.D., C.R.C. holds the rank of Clinical Professor on the faculty of the Department of Rehabilitation Counseling at the Louisiana State University Medical Center and also consults independently in vocational and rehabilitation psychology. Dr. Feldbaum received his Ph.D. and M.S. degrees in Psychology from Tulane University and his undergraduate training from Boston University. He is licensed both as a Psychologist and Vocational Rehabilitation Counselor (LRC).

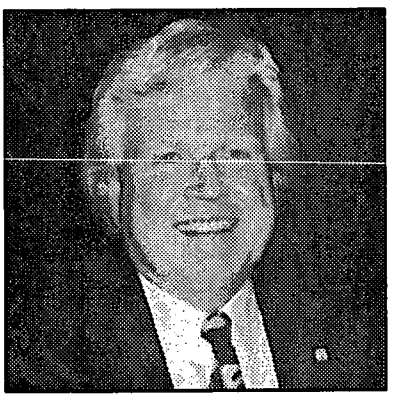
On the national level, he is a Certified Rehabilitation Counselor (CRC), Certified Vocational Evaluation Specialist (CVE), and has been awarded Diplomate status from the American Board of Vocational Experts (ABVE), the American Academy of Pain Management, and the American College of Forensic Examiners. He has taught courses at both Tulane University and LSUMC, as well as national continuing education courses to attorneys, judges, psychologists, and rehabilitation counselors. Most significantly, he is the father of three teenagers.

In the private practice of vocational rehabilitation psychology since 1979, Dr. Feldbaum has dealt primarily with determining residual employability after injury and the impact of trauma upon wage earning capacity and adjustment. He has also conducted numerous applied test validation research studies for multi-national firms including NASA's prime contractor on the Space Shuttle external tank program.

He has testified as an expert in State and Federal courts on over 130 occasions, given hundreds of depositions and evaluated thousands of injured workers involved in litigation. He has been actively involved

in a number of prominent cases involving the Americans With Disabilities Act (ADA), from both the plaintiff and defense perspectives. Current research interests include evaluating the impact of chronic pain on employability and working towards establishing an empirical basis for responsible forensic judgments regarding altered work/earning capacity. He has taught and published extensively in the vocational rehabilitation arena regarding the need for greater professional accountability in forensic practice including such topics as the evolving impact of the Supreme Court's Daubert decision on effective and ethical professional practice.

He founded and until recently co-edited the field's first journal, The Journal of Forensic Vocational Assessment, which has been recognized as the Official Journal of the American Board of Vocational Experts. Dr. Feldbaum was designated a 1998 Switzer Scholar as a representative of private sector and forensic rehabilitation.



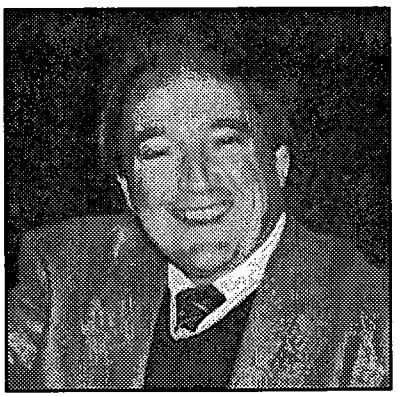
Brian Fitzgibbons, MPA, CRC

Brian Fitzgibbons began his career in Rehabilitation in 1975 working for the New Jersey Division of Vocational Rehabilitation Services (N.J.-DVRS). During the first 15 years with DVRS, he held a progression of positions in three field offices concentrating on direct services to enable individuals with disabilities to participate in the workforce. In addition to his counseling duties, he was instrumental in creating unique opportunities within the community which encouraged communication among employers, rehabilitation professionals and consumers. Job Seeking Skills classes, Job Clubs and Employer Focus Groups led to the creation of two successful placement consortia; Bergen (Assisting Disabled Applicants for Placement and Transition) and HEART (Hudson Employment Advisory Round-Table).

He was recruited to the DVRS Central Office in 1990 and served as Staff Development and Training Coordinator for 8 years. In this position, he managed the In-Service Training Program, offered direct counselor training, planned statewide conferences and made presentations to many organizations. In November of 1998, he was promoted to Chief of Program, Planning and Development, where he oversees staff development and several other special programs and grant projects.

Mr. Fitzgibbons holds a Masters degree in Public Administration from Rutgers University and has completed extensive graduate work in Human Resources. He also holds a B.S. Degree in Secondary Education with a concentration in English, from Seton Hall University. He taught high school for several years prior to joining state service and holds a New Jersey Teaching Certificate in addition to Certificates in Public Supervision and Rehabilitation Counseling.

He has been active in the National Rehabilitation Association since 1976 and has been President of the New Jersey Chapter and the Northeast Region. He joined NRA's National Board of Directors in 1993 as the Chair of the Council of Chapter Presidents and in that capacity serves on the Executive Committee and Chair of the Governmental Affairs Committee. He served as the President of NRA in 1997 and remains active in the organization.



Bruce G. Flynn, M.S., CRC

In January, 1998, Mr. Flynn began his position as Director of Disability Management for the Washington Business Group on Health, the largest non-profit research and public policy organization representing the interests of large businesses on health and disability issues. In this capacity, he works with member companies, insurers, and benefits consultants to identify best practices in the area of disability management; designs and supports research efforts focused on development of effective workplace disability management practices; and coordinates the National Disability Management Conference and Exhibit held each fall in Washington, DC.

Prior to January, 1998, Mr. Flynn was Manager of Disability Management Services for the University of California San Francisco (USCF) where he led efforts to create an integrated disability management program for the UCSF campus. From 1992 to 1997, Mr. Flynn managed the Wells Fargo Bank disability management program. He developed bankwide return to work policies, accommodation programs for employees with disabilities, and human resources and management training regarding Title I, Americans with Disabilities Act compliance.

He previously (1986 - 1992) worked as the manager of the UCSF Employee Rehabilitation Services program, chairing the Chancellors ADA task force and developing policies, programs, and training materials regarding AIDS, ADA and reasonable accommodation, workers' compensation, and managing disability in the workplace.

Mr. Flynn has been a vocational rehabilitation provider in both the public and private sectors since 1974. He has been a presenter for several national conferences, in addition to appearing in local and national print, radio, and television media concerning workplace disability and ADA compliance issues. He was an instructor with the Insurance Education Association and San Francisco State University, teaching the principles of disability management. He was a founding member of the Northern California Chapter of the Disability Management Employer Coalition.

Mr. Flynn holds a master's degree in industrial/organizational psychology from San Francisco State University and a bachelor's degree in psychology from the

University of Michigan. He is a professional member of the National Rehabilitation Association and the National Association of Rehabilitation Professionals in the private sector. He has been a Certified Rehabilitation Counselor since 1979.

Donald E. Galvin, Ph.D.

In June 1993 Don Galvin became the President/CEO of CARF . . . the Rehabilitation Accreditation Commission, the preeminent standards-setting and accrediting body promoting quality services for people with disabilities. CARF, which accredits over 18,000 rehabilitation programs throughout the United States, Canada, and Sweden, is a private, not-for-profit, voluntary organization.

From 1989 to 1993, Dr. Galvin was the Vice President for Programs of the Washington Business Group on Health (WBGH) and was also the Director of the Institute for Rehabilitation and Disability Management (IRDM).

Dr. Galvin served as the Director of Strategic Planning and as the Executive Director for Outpatient Services for the National Rehabilitation Hospital in Washington, D.C., from 1986-1989.

Prior to moving to Washington, D.C., in 1986, Dr. Galvin was a professor at Michigan State University, where he directed the graduate program in rehabilitation counselor education and also engaged in disability/rehabilitation policy research. At M.S.U., Dr. Galvin also directed the University Center for International Rehabilitation, a cross national, federally funded research and information dissemination program.

Before joining the university in 1978, Dr. Galvin was an Associate intendent of Education and State Director of the Michigan Rehabilitation Service. He also served as an adjunct faculty member in the Department of Rehabilitation Services at De Paul University in Chicago. He holds an M.A. in Rehabilitation Counseling from Michigan State University and a Doctorate in Counseling and Guidance from the University of Michigan.

Dr. Galvin was also one of the original Presidential appointees to the National Council on Disability.

Eddie Elaine Glenn, Ph.D., CRC, LPC

Eddie Glenn has served as an associate professor in the Rehabilitation Counselor Education program at Illinois State University since the 1994-1995 academic year. She received her education and training at the University of South Carolina, The Ohio State University, University of Pennsylvania, Medical School of South Carolina, and South Carolina State University. She has a doctorate in counselor education, two masters' degrees; rehabilitation counseling and school guidance, and a graduate certificate in gerontology. Dr. Glenn has also taught at The University of Arkansas-Fayetteville, South Carolina State University and the University of Alabama-Tuscaloosa. In addition, Dr. Glenn has worked in numerous human services agencies (i.e., vocational rehabilitation, mental heath, and colleges and public schools) in various positions such as counselor, work adjustment specialist, vocational evaluator, school counselor, and teacher.

During her career, Dr. Glenn has acquired expertise in the following areas: rehabilitation counseling and education, multicultural counseling, women of color with disabilities, gerontological issues, blindness, mentoring programs, counseling children and adolescents with disabilities, alcohol and substance abuse and African-American male academics and pedagogical issues. Dr. Glenn is a Certified Rehabilitation Counselor, Licensed Professional Counselor and has a current teaching certificate. She is an active member of the National Rehabilitation Association, the American Counseling Association and several of its divisions, including multicultural, rehabilitation counseling, and counselor education. Dr. Glenn is also active in the Midwestern Educational Research Association, American Education and Research for the Blind and Visually Impaired, and Chi Sigma Iota; an academic honors society for counselors.

Dr. Glenn has held several offices and chairs, as well as, served on several boards and committees on the national, regional, state, and local levels. She has published and presented on numerous occasions on topics of her expertise. In addition, Dr. Glenn has developed several programs and models that can be used in educating and training professionals and rehabilitating individuals. She has been very active in university, community, and church activities. Dr. Glenn has received several honors and awards and has received many certificates of appreciation. She has been awarded several federal grants for research and training. Dr. Glenn was diagnosed with sarcoidosis in 1980, and since then she has helped to focus national attention on this disease, through her public and proactive stance toward educating others, and through her advocacy in working with others diagnosed with this same condition.

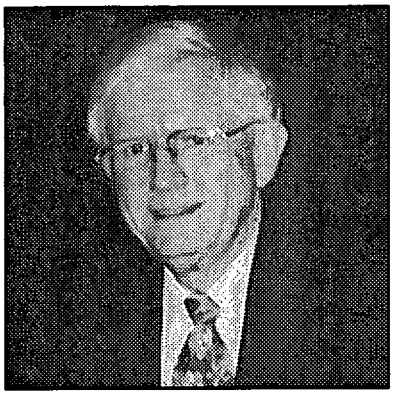
Carl Hansen, Ed.D.

Carl Hansen has been in the field of vocational rehabilitation since 1965 after he

received his Master's Degree from the University of Northern Colorado. After working for the California Department of Rehabilitation, he returned to the University of Northern Colorado and completed his doctoral degree. He served as a professor with the University of Texas at Austin for 26 years with most of those years in the position of Director of the Vocational Rehabilitation Counselor Education Program. Upon his retirement in 1994, he continued to operate his private business known as Vocational Appraisal and Planning; a counseling and forensic rehabilitation program established in 1975. Dr. Hansen served as President of the National Rehabilitation Counseling Association in 1974 and President of the National Rehabilitation Association in 1978. He continues on a number of local and national boards related to vocational rehabilitation as well as one financial institution. He has served in the role of Switzer Chairperson for the last ten years.

Geraldine Hansen, Ed.D.

Geraldine Hansen, Ed.D. is Coordinator of the Regional Rehabilitation Continuing Education Program (RCEP) as well as professor for the Graduate Rehabilitation Counseling program at Assumption College in Worcester, MA. Prior to joining the College twelve years ago, she was a program evaluator, researcher and rehabilitation counselor.



Harold Kay, Ed.D.

Harold Kay is the Director of Evaluation for the Rehabilitation Services Administration (RSA). In this capacity, he oversees evaluation grants and contracts and special studies, and currently is responsible for the implementation of the V.R. Performance Indicators and Evaluation Standards. Dr. Kay's experience in rehabilitation spans over thirty years and includes work in Florida as a Vocational Rehabilitation Counselor, a facility Rehabilitation Director and Director of a Facility Evaluation project. Before coming to Washington, he worked as an R.S.A. Regional Representative for Region III in Philadelphia.

Dr. Kay received his M.A. in Education/Government from Florida State University. His doctorate was obtained from the University of Florida in the field of Education Administration.

Michael Leahy, Ph.D.

Dr. Michael Leahy is a Professor and the Director of the Office of Rehabilitation and Disability Studies at Michigan State University. He has a doctorate in Rehabilitation Counseling Psychology from the University of Wisconsin-Madison, and over 20 year of experience in rehabilitation as a counselor, administrator, researcher and educator. Dr. Leahy is a Licensed Professional Counselor (LPC) and a Certified Rehabilitation Counselor (CRC). His continuing research interests include issues related to professional competency development and education, professionalization issues, problems of disability in the work place as they relate to prevention and management, vocational assessment practices, case management, and vocational outcomes.

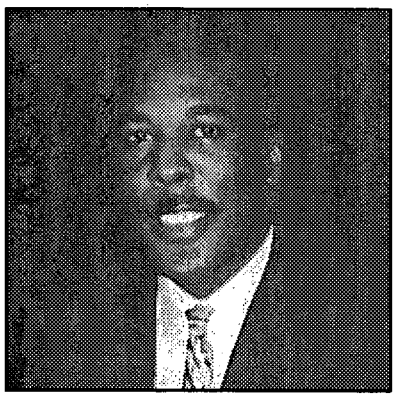
Dr. Leahy is currently the Past-President of the National Council on Rehabilitation Education, a Past-Chair of the Alliance for Rehabilitation Counseling, and a Past-President of the American Rehabilitation Counseling Association (ARCA). He has published more than 60 journal articles, books, and book chapters and presented his research to a variety of rehabilitation and business audiences, including international presentations. He is a three-time recipient of the American Rehabilitation Counseling Association Research Award (1986, 1990, 1993), recipient of the 1995 American Counseling Association (ACA) Research Award, 1994 Rehabilitation Educator-Researcher Award from NCRE, 1993 Award for Outstanding Leadership by ARCA and NRCA, the 1989 Outstanding New Career Award in Rehabilitation Education, 1997 ARCA Professional Service Award, recipient in 1997 of the Lifetime Rehabilitation Achievement Award from CRCC, and was honored as a Switzer Scholar in 1998 by the National Rehabilitation Association.

Kevin F. Manning, M.A., CRC

Kevin Manning is a self-employed consultant in private sector rehabilitation and on staff as a Rehabilitation and Mental Health Counselor at St. Luke's Hospital Outpatient Mental Health Clinic, New

Bedford, MA since 1987. In addition to managing a caseload of thirty to fifty persons with disabilities and consulting to insurers, he also serves on two volunteer Board of Directors, Cooperative Productions, Inc. and Community Partnerships, Inc. in Southeastern MA. Mr. Manning has been an active member of the Massachusetts Chapters of the National Rehabilitation Counseling Association and National Rehabilitation Association; serving as State Chapter President, Northeast Region President and 1995 Conference Chairman, Eclectic Rehab News Editor, and Massachusetts Legislative Chairman. He has been actively involved in state legislative issues and presently, his state N.R.A. Chapter is actively seeking passage of third party reimbursement for rehabilitation counselors.

Mr. Manning received his Masters in Rehabilitation Counseling from Assumption College and completed undergraduate studies at the College of St. Thomas in St. Paul, MN. He is a Certified Rehabilitation Counselor and also holds State licenses as both a Rehabilitation and Mental Health Counselor. On a personal note, he describes himself as happily married to Carol E. (Waters) Manning. Mr. Manning is an proud participant for the past ten years in the Pan Mass Challenge, the two day, 200 mile, largest bicycling fund raiser, in which 2200 riders this past year (1998) raised for the Jimmy Fund of the Dana Farber Cancer Institute in Boston, 6.7 million dollars. Cycling represents Kevin's other passion.



James L. Mason, MSW

James L. Mason, owner/director of J.L.M. and Associates, is the cultural consultant [illegible]e Georgetown University Child Development Center National Cultural Competence Center on Maternal and Child Health. He is an assistant professor at the Graduate School of Social Work at Portland State University. He is a member of the Child and Adolescent Service System Program (CASSP) Multicultural Resource Committee of the Georgetown University Child Development Center; and is the former Director of Training and Principal Investigator for the CASSP National Research and Training Center on Family Support and Children's Mental Health in Portland, Oregon.

Mr. Mason is a doctoral candidate in the Urban Studies program at Portland State University. He has worked in the field of health and human service research, program development, and program evaluation for twenty years. He currently conducts cultural competence workshops, performs agency cultural competence assessments, and provides consultation to health and human service organizations and professionals around the country.

Beth Robertson

Beth Robertson is currently Vice President of Employment and Training Services for Goodwill Industries of Akron, Ohio. In her current position she directs rehabilitation services for a wide spectrum of consumers and funders and also leads the industrial services division of the agency. Under her direction, Goodwill of Akron serves over 3,500 people each year, assisting them in obtaining and maintaining employment in the community. Beth provides leadership to a staff of over 80 professionals whose goal is to provide quality services and responsible outcomes to the people who come to Goodwill with various barriers to employment.

Robertson's career and accomplishments in the Employment and Training field include innovations in program design to enhance community employment opportunities for those with severe disabilities, as well as services designed to improve the opportunities, outcomes and benefits of those leaving the welfare system. Goodwill of Akron also works extensively with individuals who have been downsized or laid off and assists them with retraining or replacement in the community through contracts with the Private Industry Council. Goodwill is extensively involved with the One Stop System of employment service delivery in Ohio and Robertson serves on the County Workforce Development Governance Board. Robertson is extensively involved in the Goodwill International pilot project with the National Results Council designed to provide accountability systems and measures for community employment and training providers.

Robertson is a member of the National Rehabilitation Association, Summit County Board of MR/DD Planning and Priorities Committee, Medina County Career Center Advisory Board, Valparaiso University Alumni Association, Akron Adult Education Advisory Committee, Medina County Family First Council and the Summit/Medina County One-Stop Governance Board. She and her family are members of Fairlawn Lutheran church where she serves as chairman of the Education Ministry.

Robertson began her career in Valparaiso, Indiana as Vice President of Rehabilitation Services for Opportunity Enterprises. She joined Goodwill in 1994 as Vice President of Employment and Training.

Peggy D. Rosser, M.Ed.

Peggy D. Rosser director of the Georgia Division of Rehabilitation Services (DRS), is a native Atlantan. She received her B.S. degree in education in 1974 (cum laude) and her M.Ed. Degree in rehabilitation counseling in 1982 from the University of Georgia.

Peggy has been employed by DRS, which is a division of the Department of Human Resources (DHR) since 1977, progressing through the ranks from senior secretary, to senior rehabilitation counselor, then to staff assistant to director, to center manager of the Atlanta Rehabilitation Center, to the level of deputy DRS director. In January of 1996, she was appointed DRS director. She is a vocal champion for issues affecting all persons with disabilities, especially those individuals from diverse cultures.

During her career, she has been honored by a number of organizations for her professional achievement. In 1996, the Georgia Association of Multicultural Rehabilitation Concerns established an annual award for excellence, naming it the Rosser Award; Peggy was the first recipient of this award.

In addition to her designation as a 1998 Switzer Scholar, she has also been recognized as the DRS Employee of the Year./Superstar, the Atlanta Association of Retarded Citizens Counselor of the Year, the Dr. Irving H. Goldstein Counselor of the Year, the DRS Employee of the Quarter, the DRS Employee of the Year/Special Achievement, and the Georgia Association of Rehabilitation Secretaries Boss of the Year. Peggy has also received the Georgia Rehabilitation Association New Member Spirit Award and is a graduate of Leadership DHR.

is an active member of the Georgia/National Rehabilitation Association, the Georgia/National Rehabilitation Administration Association, the Georgia/National Association of Multicultural Rehabilitation Concerns (G./NAMRC), and the Georgia/National Association of Rehabilitation Support Staff. She has served as a national board member for NAMRC.

Peggy and her husband Ron live in Atlanta and have two children.

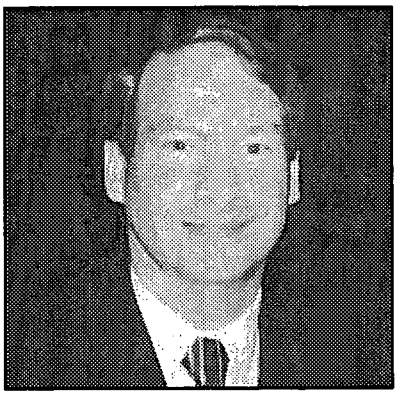
Janice J. Skinner, MA, CRC, LPC

Jan Skinner has been in the field of rehabilitation counseling for eighteen years. She received her MA in Guidance and Counseling in 1977 from Michigan State University and has had several rehabilitation counseling courses at Wayne State University. She has been a Certified Rehabilitation Counselor since 1982 and a Licensed Professional Counselor since 1991.

At the present time employed by Michigan Jobs Commission-Rehabilitation Services, the state-federal rehabilitation agency, Jan started her counseling career as an employment and training counselor with the CETA program in Warren, Michigan. She then worked in the field of private rehabilitation, with two small private firms, Rehabilitation & Placement Associates and Rosko & Associates, as well as operating as a sole practitioner for seven years. She has been with MJC-RS for the last five years.

Jan has been very active with both Michigan Rehabilitation Association (MRA) and Michigan Rehabilitation Counseling Association (MRCA), currently serving on the Michigan Rehabilitation Association Board of Directors and acting as their membership chair. She has been involved with MRA's Legislative Affairs and Professional Issues Committees, and was formerly co-chair of MRCA's Licensure Committee. Jan is past chair of MRCA's Certification Committee and continues to assist with continuing education certification for MRCA. She was named MRCA's "Counselor of the Year" in 1990.

Jan has been married for 28 years to Ralph Skinner, Art Director for America's Thanksgiving Parade. She and Ralph have one daughter, Errin, who currently is volunteering with VISTA in Harrisburg, PA. Errin recently graduated with a degree in social work from Michigan State University.



Thomas G. Stewart

Thomas G. Stewart was born a few blocks from the United States Capitol building in Washington D.C. Tom grew up in the Virginia suburban area of Washington, D.C. and graduated from George Washington University.

He began his service with the United States House of Representatives with Congressman Gus Yatron from Pennsylvania. After a year with Congressman Yatron, Tom was offered the Chief Casework position in the office of Congressman Frank Annunzio from Illinois. Over fourteen years, he worked in increasingly responsible positions with Congressman Annunzio culminating as Congressman Annunzio's Legislative Director.

In the mid-1980's, Tom took a break from Washington and accepted a position as a Legislative Fiscal Analyst for Education Agencies with the Oklahoma State Senate. After being away just a year, Tom returned to the Washington area and was asked to rejoin the staff of Congressman Annunzio. He remained

with Mr. Annunzio's office until the Congressman's retirement.

In addition to his work on Capitol Hill, Tom has twenty-five years experience working in political campaigns. During this time, he has worked in virtually every campaign position from a door-to-door volunteer to deputy campaign manager. Because of his political work, he has been listed in Who's Who in American Politics since 1981. He has been elected to countless state and local political conventions, served on numerous convention committees, and was an elected delegate from Virginia to a national political convention.

In May 1994, Tom joined the staff of the National Rehabilitation Association as the Association's Director of Governmental Affairs.

Kimberly A. Turner, M.Ed.

Kimberly A. Turner, M.Ed., is currently Associate Director for the Center for Disability and Socioeconomic Policy Studies and the Howard University Research and Training Center for Access to Rehabilitation and Economic Opportunity. Ms. Turner has more than 11 years of experience in the area of rehabilitation, cultural diversify, and disability legislation. She is currently a doctoral student in the Department of Human Communication Studies at Howard University.

Carolyn Vash, Ph.D.

Dr. Vash has worked in the field of rehabilitation for 40 years. Trained as a psychologist – Ph.D. from the University of California in 1964– she worked as a clinician at Rancho Los Amigos rehabilitation hospital in Downey, California. She developed a new Vocational Services Department at the hospital and then became Chief Deputy Director of the California State Department of Rehabilitation. She served as Vice President of the Institute for Information Studies in McLean, Virginia where her interests centered on dissemination and utilization of rehabilitation research findings. She currently devotes full time to writing. She is now working on the third book in a series that began with The Psychology of Disability [available in English and Portuguese] followed by Personality and Adversity: Psycho spiritual Aspects of Rehabilitation [available in English only].

John D. Westbrook, Ph.D.

John D. Westbrook is Director of the National Center for the Dissemination of Disability Research and Program Manager of the Special Education and Rehabilitation Services Program at the Southwest Educational Development Laboratory. Westbrook has extensive experience in disability and dissemination/utilization.

Westbrook's experience in dissemination and utilization is reflected in his previous roles as Dissemination Specialist for the U.S. Department of Education-funded Regional Exchange project addressing needs of state education agencies. Westbrook has extensive personal experience in the provision of training and technical assistance services at the state, regional, and national levels; he has facilitated multiple technical assistance brokerages aimed at the improvement of service outcomes for people with disabilities. He has worked to develop a comprehensive facilitation process for assuring utilization of disseminated information within disability-related organizations, as documented in The Provisions of Technical Assistance in Vocational Rehabilitation (University of Wisconsin-Stout, 1989).

Additional work and service experiences of Westbrook have included the following: member of the Board of Directors of the Austin Resource Center for Independent Living, special education teacher and administrator, consultant for the Multiply Disabled Hearing Impaired Planning Project operated by the Texas Education Agency and the Texas Department of Mental Health and Mental Retardation (TXMHMR), Staff Development Specialist for the TXMHMR, and Continuing Medical Education Staff Development Specialist for the Texas Research Institute of the Mental Sciences.

Westbrook holds a Bachelor's degree in Speech/Education of the Deaf/Hearing Impaired, Master's degree in Special Education/Language and Learning Disabilities, and a Doctorate degree in Educational Administration/Special Education Administration. He has authored a variety of articles and reports in the disability area.

Responsibilities of People with Disabilities

Carolyn Vash

Dr. McConnell's letter of invitation indicated that my paper should address the "accountability/responsibility" of people with disabilities to various categories of people and organizational systems. I've chosen to feature the qualitative "responsibility" rather than the quantitative "accountability" for two reasons. For most areas in which I perceive an obligation, I can imagine no practicable way of accounting for either what I received or might repay. And, bluntly, I see our contemporary passion for quantifying everything that happens here on planet Earth as having long since overshot the runway of useful ideas and crashed into the jungle of those brought to absurd overuse.

[This seems to be a symptom of scientistic materialism, a pathology born of reifying scientific materialism--a perfectly respectable but arbitrarily chosen working assumption with no truth status--and the radical reductionism that has resulted from it. I'm through ignoring the obvious fact that fully half of life is subjective, not objective. Attempts to collapse the depth of conscious, interior experience to the empirical flatland of externally observable objects and behavior I have put away with childish things. Those referred to here are the human needs to simplify the nonlinear complexity of the universe in which we find ourselves--which sometimes threatens to overwhelm us--even at the cost of oversimplifying to a pathetic degree.]

On the other hand, I'm adding attitudes of appreciation to what I feel I and perhaps others with disabilities may owe to various people and institutions in return for help received along the way. As intended beneficiaries of time, effort, and sometimes massive funding--regardless of how badly the process might go awry and fail--I'm perpetually glad the human spirit includes a generous scattering of impulses to help.

In offering my perspectives. I'll proceed more or less chronologically in an effort to recapture the thread of life on which my debts--paid or still outstanding--are strung.

The Early Days

I figure I owed it to the nursing staff in the communicable disease ward to not be a brat even though I was seriously consternated, at age sixteen, about suddenly being unable to move anything below my neck. Mostly, I behaved well. I probably shouldn't have accepted my friends' offers to give me puffs from their cigarettes when I was in an iron-lung respirator, but it was too tempting--and the process too fascinating--to just say no. Otherwise I was a model patient and the staff loved me. They did not love my mother.

The reason I was able to be cool about it all was that I had not been forcibly separated from my main source of security, as most youngsters are when they end up in hospitals.

When the nurses told my mother it was time for her to leave for the night she said, "No." They said they were sorry but it was a rule. She called her buddy, the County Health Officer, who dashed over and told the nurses she could stay. The defeated nurses made her pay...by letting her sleep in a chair despite numerous empty beds on the ward; by drinking coffee without offering her any; and mostly--for a woman needing a little moral support for herself--by snubbing her, acting as if she weren't there.

I owe mother and Dr. Russell more than I can ever repay for having the instincts to know what was psychologically the right thing to do for me, and for caring enough to face the consequences of saying, in essence, "Damn the rules--we'll do what's RIGHT!". Dr. Russell had to take some punishment too, for siding with the enemy and causing the nurses to lose face. In my role as a person with a disability there's not much I could do beyond expressing heartfelt thanks. I don't belittle the value of expressing gratitude; you all know how much you treasure such expressions from clients and former clients. But after becoming a rehabilitation professional and administrator there was more I could do to amplify the benefits of the gutsy duo's sacrifice. In staff education I stressed the importance of knowing when to interpret rules as soft guidelines, for psychological reasons; and in hiring rehabilitation personnel, I weeded out applicants who seemed unable to grasp this ideal.

I may have been a darling girl in the hospital, but a few months after going home, when I finally "got it" that I was going to be more or less quadriplegic on a permanent basis, I got seriously cranky. Guess who was my whipping boy...good old mother. I've been a rehabilitation professional for 40 years now and all

Carolyn Vash, Ph.D., Rehabilitation and Disability Author, 35 Flores, Drive, Altadena, CA 91001.

that time I've been preaching that "Disability doesn't just happen to the identified patient; it happens to the whole family." Notwithstanding the fact that it's true, my zeal reveals attempted expiation. I don't like to remember even now what a horrid little ingrate I was in those early years when I did not meet the responsibilities I now recognize: to realize I wasn't the only one whose life had been whacked out of orbit, and try to reciprocate a little of the support that was coming unstintingly to me.

One social institution deserves enormous credit: the National Foundation for Infantile Paralysis. My family and many others owe them big time for the enlightened policies that did not strip beneficiaries of their dignity in the process of providing financial help--as its public counterpart, SSI-linked Medicaid, would later do. Many observers have commented that the "old polios" have a strength not found among people with other disabilities. I think it is in part because we had the National Foundation to provide the attendant care we needed without putting us through a mortification process that culminated in achieving poverty status. That may be necessary in order to protect taxpayers' money, but it breaks spirits in the process.

The School and Rehabilitation Service System Years

For this stage of life I must turn to contemporary experiences of others because relevant debts are sparse in my personal history. I finished my last year of high school with a pleasant but mediocre home teacher because there were stairs and no elevators at my school. Today, I'd probably return to my high school which would be retrofitted with ramps and elevators. And I'd sign and IEP and be responsible for whatever I'd agreed to. I'm not sure this would be true of all students in similar situations. I was tough enough at 16 to refuse to sign anything I wasn't truly committed to, but many teenagers aren't. They sign because they think they have to; they haven't been raised to expect full, genuine participation in decisions governing their lives.

Next I attended the local junior college which had, quite accidentally, a wheelchair-friendly campus. I was turned down by the state vocational rehabilitation (VR) agency because my goal of becoming a psychologist was "unrealistic." For upper division work I transferred to the nearest state college. There I became indebted to dozens of husky young men who hauled me and my wheelchair up flights of stairs to second-floor classrooms for three years. My accountability to the taxpayers, politicians, and so forth was either the same as any non-disabled student's or a little bit less, since I had to further risk life and limb to make use of tax-supported college facilities.

I tried once more to get financial help from VR after being accepted in the UCLA doctoral program and was turned down this time because I didn't need it; clearly I would finish whether I got help or not. So trusty old mother mortgaged her house and paid. If I had been accepted, as I probably would be today, then I'd have signed and IWRP and be responsible for keeping whatever agreements I'd made.

I probably owed it to the world to appeal these decisions not [illegible]p me. By today's standards, they were inappropriate. But in the late 1950's, it was an idea that never occurred to me. Thirteen years later I was appointed to the first Rehabilitation Appeals Board--so I did take action eventually. On the light side, four years after that, on the very day the governor appointed me to serve as Chief Deputy Director of the State Department of Rehabilitation, the counselor who made the first decision resigned from the agency. It's unlikely that he would have remembered my name, but an intervening marriage had changed it anyway so the coincidence is undoubtedly just that.

People who are accepted for services owe it to others who are accepted--and to the personnel in the service system--to complain when the services they receive are inappropriate or inadequate. It's obvious why they owe it to their peers; here's why they owe it to agency personnel. The reason voucher systems keep getting proposed about every decade or so is that someone in Congress or the OMB takes note of the fact that the job placement rate across the state-federal VR system is for from stunning; and former clients are not giving rave reviews to the quality of services they received. I say a buddy would send up a warning flare.

I'm admittedly out of date, having left the VR system in 1977, but at that time the weakest competency areas for counselors were in entrepreneurial and artistic careers. As people who choose safe, civil service careers for themselves, they have little ability to resonate with the desires and needs of clients who are willing to try for these higher risk occupations. The irony is, these may be good bets for clients who have the right stuff for them and who are visibly disabled enough to face multiple rejections by employers. Maybe things have changed in these areas, but I'll bet there is still room for improvement.

After getting stabilized financially, I figure I'd owe somebody something in return for whatever I got. For example, if I'd been provided equipment that could be useful to another when I was through with it, returning it would be a responsibility I'd feel. Today, that might involve assistive technology which had been upgraded for my use while the older model could still be useful to someone else.

The Work and Social Action Years

I owed it to whomever was paying my salary to be as punctual as all other employees were expected to be. I owed it also to whomever would have had to take up the slack or make excuses or rearrange schedules if I'd been late. This leapt to mind because I've long been annoyed by the habitual lateness to work and meetings which I've observed among colleagues with disabilities. An occasional lapse is understandable, especially for severely disabled individuals trying to cope in hotels that claim to be wheelchair accessible but aren't. But chronic lateness, in or out of town, tells me the person has too little ability to learn from experience and plan ahead, or too much self-indulgence and disregard for others, or too much willingness to exploit non-disabled individuals' reluctance to confront them.

Similarly, I think we who need special assistance in boarding airplanes owe it to airline personnel to show up a full hour ahead of flight time like they ask us to. We are more trouble than other customers and don't get charged extra for it, so if a little extra time

helps them cope, why not be generous? At the same time, we who are frequent flyers owe it to ourselves, each other, disabled people who are presently barred from flying, and non-disabled flyers who will one day join our ranks, to unrelentingly demand that every commercial aircraft that has a restroom for anyone have one that is wheelchair-accessible--even if it requires losing a row of seating capacity.

I don't use the word "demand" recklessly. Making too many of them dilutes the power of each one made. I don't like to waste my shots so I use them sparingly. It's fashionable these days to demand that others use politically correct language with respect to disabilities. I consider that worse than a wasted shot. We've already seen how euphemisms defined as politically correct can ricochet and become fodder for jokes at our expense--in proliferating "challenged" and "differently abled" parodies. Beyond that, telling people how to talk is unconstitutional. It gets worse; some zealots even want to dictate people's inner thoughts and feelings as well as their behavior.

I'll elaborate. As a writer, no one is going to successfully require me to always "put the person first," disallowing even the literary variety of alternating "person with a disability" with "disabled person." I think the language-police tactics are especially galling to me because, to my knowledge, I was the first person to articulate the idea of "putting the person first"--in a pamphlet I prepared for staff at Rancho Los Amigos Hospital in 1959. I reiterated the material in various articles published during the 1960's. I wish people who cite those sources would read them carefully enough to know that I offered suggestions to people who want to join me in using language in ways that might subtly diminish negative attitudes about disabilities and the people who have them. I did not issue first-amendment-abridging orders to the entire populace.

Every idea gets altered by later thinkers. Many of mine have been transformed for the better by others who re-thought them. I don't feel that way about this one. The descent from a respectful suggestion for people presumed to be of good will, to a peremptory proclamation of law to fools who must be edified reached bottom, in my opinion, in a grant proposal I peer reviewed several years ago. The author wanted to take the good news about disability rights to Russia, where attitudes about disability and disabled people were considered especially bad. This was attributed largely to the influence of Bolshevism. The author's justification of why it was important for her to travel there to conduct her mission culminated in the fiery conclusion: "These attitudes must stop!"

In the margin I wrote: "And just who is going to tell me how I must think and feel? This is what made the Bolsheviks worse oppressors than the Tsars...the conviction that they had a right to dictate not only behavior, but private, inner attitudes as well." After submitting the evaluation, I resigned from peer reviewer status. Clearly, I'd lost patience with much that is mainstream; it seemed time to drop out.

There's one further step to take with this particular sortie into responsibility. While appreciating the power of language to alter will, to eventually rise above the need to have others use politically correct language to us or about us. I think we owe it to ourselves and the Universe, if you

will, to eventually rise above the need to have others use politically correct language to us or about us. These thoughts have been published before and they've been studiously ignored but I'll try again. As long as my happiness is contingent on your choice of words, I'm in a state of psychological dependency that strikes me as pretty pathetic. I'll never be free as long as what some jerk says about me or some group I belong to matters enough to bring down my mood. As I see it, my responsibility to Life and to my psychological and, perhaps, spiritual evolution, is to transcend dependence on others' language for feeling okay about myself. My responsibility to you is to honor your requests [not orders] to be addressed or referred to in preferred ways and to comply as much as possible. The limits to my compliance have to do with making enough sense to me that I can remember what you want, and not entailing too many extra syllables.

You may refer to me in any way you wish; I find all forms of address and reference interesting and sometimes psychodiagnostic. I do quite a few keynote addresses and being introduced as "Someone less fortunate than the rest of us" still takes me by surprise, but I've adjusted; after all these years, I no longer look behind me to see who they mean. I often self-introduce as "little old crippled lady;" it unfailingly gets the attention of senior and feminist as well as disabled political-correctness addicts.

Here's a really touchy issue. It seems that members of groups traditionally excluded from positions of power run into trouble when they are first appointed to such positions. A disproportionate number of female and ethnic minority appointees to high office are charged with misuse of public funds on behalf of cronies or comparable malfeasance. It is hard to know whether they actually do more naughtiness than their traditional counterparts; whether they lack the critical mass of experience and experienced cohorts to help them cover their tracks as well as traditional appointees; or are simply prosecuted more zealously when suspicions arise. I suspect all three may be true, in view of the parallel processes I've observed regarding disabled people who've enjoyed positions of authority. People who have power for the first time, perhaps in their family or "tribal" histories, may fall into an enthusiasm of largesse that is truly innocent, in the classic sense of purity of heart, and in the contemporary sense of ignorance of the ethical standards involved in stewarding taxpayers' monies.

A paraplegic lawyer was suspended by his State Bar association for an infraction that fully deserved suspicion if not permanent disbarment. What bothers me is the fact that literally hundreds of non-disabled attorneys in the same State have been charged with the same or more serious offenses and they are still practicing law while their cases lie backlogged. Why was only the paraplegic's case expeditiously handled?

Several disabled people appointed to offices with considerable budgetary discretion are widely believed to have deployed funds on behalf of favored individuals or institutions with questionable eligibility to receive them. People gossip, but no one, in-group or out-group, makes charges. There seems to be a "granting of allowances" that has not been made for female, ethnic minority, or even traditional appointees. I think we who hold such offices owe it to ourselves and the reputation of the disability community to avoid this sort of thing assiduously, and to blow whistles as

our consciences dictate when members of our collective behave unethically.

It is inevitable, I suppose, that a discussion of responsibilities would devolve upon ethical dilemmas. An illustration involves the absurdly inappropriate job assignment of a blind man to a position that demanded a moderate but crucial amount of visual inspection. When the administrator who made the assignment told me of it, I pointed out the flaw in his reasoning, only to be told, jocularly, "My! You're the last person I would have expected to be against hiring the handicapped!" The truth was, I learned later, the fellow's visual disability was considered less handicapping to his work performance than his "passive personality." He was deliberately assigned to the only job which would produce regular contact with me, on the admittedly flattering premise that if anyone could get him to function, I could. I did not live up to these irrational hopes. I failed utterly to render a blind man capable of doing visual inspection.

A couple of years later, when the administrator was replaced, I asked the new one to correct the mis-assignment so we could catch up with more than a year's worth of work that had laid moldering in his desk. This administrator, selected from a pool of candidates required to have disabilities but not administrative experience, handled the matter inexpertly. Two levels of middle managers who's known of the problem but done nothing about it became vociferously defensive. Catching up seemed impossible. As flak rained down, the easiest decision was to decree that the project lacked merit anyway and might as well be discontinued.

Would I speak up again after that experience? You bet I would. This organization eventually became a laughing stock within its field as the quality of its output dropped. Especially unfortunate is the perception of critics that the reduced quality is an outgrowth of commitment to hiring workers with disabilities--a perception that hurts every member of the disability community to some degree. Misguided affirmative action is only one factor among many in this case, but it's the factor I'm focusing on here.

Facing the consequences of firing disabled workers who prove to be "bad hires" is harder for nearly all managers than firing other employees, including ethnic minority members. It seems most would rather be viewed as bigots or sexists than mean monsters. Misguided kindness to a few ends up hurting them as well as others in the long run. One man who knows he's not producing lives in fear that the ax will fall in the next moment. I believe chronic fear is implicated in his development of a serious stress-related illness. Still, because I'm annoyed that he's 1) willing to take a large salary while giving almost nothing in return for it, and 2) too fearful to quit a job he knows he can't handle and try to find one he can--I feel more concern for other disabled workers who'll pay for his self-protectiveness. The cost is reduced job opportunities for workers with disabilities offered by observing employers made nervous about their probable competence.

I know it isn't fair for people to generalize from one incompetent disabled worker to all others, but we live in a world filled with overgeneralizers, stereotypers, people who pre-judge others on the basis of visible characteristics that are irrelevant to the [illegible] at hand. And it's reality, not some ideal, that we must adapt to in our lives. If we care about helping other members of our "disabled tribe," we'd better acknowledge the admittedly unfair reality that what we do affects our tribe mates whether we intend it to or not.

Speaking of helping our group mates, there are many opportunities these days to serve as role models and mentors to young people with disabilities. The idea is to let them see that people with disabilities like theirs can actually "make it" economically and pursue happiness...and catch it. I think it's important for as many of us as possible to get out there in the public eye so youngsters can see us doing what they might want to do. Some championing may require mentors with similar disabilities for functional, experimental reasons. But I'm alarmed at the insularity that characterizes many role model and mentor programs I hear about for girls, ethic minorities, and disabled youngsters. I fear we limit their imaginations, their horizons, their abilities to perceive possibilities, and--most of all--their tendencies to identify with ALL of humankind--not just those who look like they do--when we assume that girls must have female role models and mentors, ethnic minorities need matching minorities, and disabled kids need disabled grownups.

When I was junior high school age, Sigmund Freud was my number one role model. I wanted to be like him when I grew up--a brilliant psychological theorist. It never occurred to me that a problem existed because I was a little girl and he was an old man. I'd been brought up gender-blind by a mother who was no feminist--they were considered far-out weirdos in the 1940's--and not sex-blind either; just gender-blind. When other little girls got nurses' paraphernalia for Christmas, I got a doctor's kit. Mother probably didn't even know the other parents chose nurses' gear for their daughters, but I did because I played at their houses.

Mother was my main mentor; I can identify no others of lasting significance. Because she was such a multi-faceted personality, there was a side of her that could respond to just about anything I came up with. But she pointed me toward role models in history and in real life--people who had mastered skills I thought I wanted or needed. She helped me find them in books and in the community. Most of them were men, which didn't faze me. So what? If one person can do it, why not another?

I think having a virtually the entire pool of humanity with whom to comfortably identify served me well. By contrast, I think limiting youngsters' ideas of who they might hope to emulate serves them very, very badly. Its not the demography that needs to be matched in forming powerful, helpful role model and mentor connections--it's the interest, the enthusiasm, the passion, the fascination which whatever turns them on--that's what needs to be matched. Demographic matching that masquerades as an aspect of celebrating diversity is, in my opinion, exactly the opposite. It fosters separatism, segregation, polarization, and re-tribalization when what we need is integration, cooperation, pooling, and sharing.

The Retirement and Life Review Years

During most of my career I did work I enjoyed enough to do as a volunteer if no one was willing to pay me for it. Now that I'm

sliding into retirement, I'm writing invited articles, giving keynote addresses, and writing my last book--actually, a three volume work that I regard, admittedly hyperbolically, as my Magnum Opus. Career came easy. Once, to my embarrassment, after a talk on the importance of emotional support during job search, someone asked me to share my personal experiences. Zero. Every job I ever held dropped into my lap like a ripe plum. Life's had no shortage of struggles; they've simply existed on a different plane. I'll save that for last since I believe sharing what I've learned from my unique blend of experiences is the highest responsibility I face in this life. I experienced the Social Security Disability Insurance system this year. I've known about it for many years, but knowing about and Knowing are radically different. I'm appalled at the presumption greeting applicants at every new desk in the process: you're not really disabled; you're trying to defraud the government of undeserved benefits.

I admit I've been a tad touch about SSDI eligibility determination since they killed my former husband a few years ago. Because he looked like a suntanned, silver fox, they couldn't believe that two open heart surgeries had really taken a toll on his stamina and they turned him down. He took the only job he could get to support his family--motel maintenance--and was dead from congestive heart failure before his case came to appeal. My case is not so dramatic. I'm simply having to drop out of regular employment nearly a decade before I expected because, after 47 years of overuse, the hundred or so muscle fibers that have been doing the work of a couple thousand for all that time, allowing me to write, edit, and illustrate 10 hours a day, then 8, then 6, then 4, and now less than 2, have just plain had it. They can't keep up a pace commensurate with salaried employment anymore.

I was on private disability benefits for two years. When they ran out, I applied for SSDI. I could have settled for the age 62 level of retirement benefits to avoid unpleasantness. I chose to fight for the SSDI/age 65 level. The difference of $150 per month may not matter much now, but in fifteen to twenty years--I come from long-lived stock--it could be a difference that makes a difference. People ineligible for long-term care insurance can expand even substantial savings fast. I was treated shabbily, but no worse than many others. People less psychologically tough or more desperate financially could be harmed by gratuitous stress imposed by a putative source of help at the uniquely vulnerable moment of facing the fact that you just can't hack it anymore.

I'd been warned that examining physicians give applicants about 15 minutes, but I was with her more than an hour. After complaining about stunning rudeness by a receptionist, I acknowledged that clinic staff were in a situation similar to police who become jaded by their daily experience. The doctor nodded ascent and said they try to greet each new person with a fresh mind. Speaking for herself she added, "I'm a professional."

Not by my definition. The doctor told me, an applicant, that she "couldn't stand" the state VR director because she had once joked that 'some of her best friends are doctors'. She added: "That girl needs to realize its not MY fault she's blind!" I was astonished to hear this tired cliché of "cripple trashing" fall from the lips of someone who had only moments earlier spoken of pre-judgements she experiences because she is "black". I tried to distinguish the [illegible] expressed by the disability community toward mainstream medicine from the stereotyping she experiences as a "black" and I experience as a "cripple". The disability v. medical charges issue from the "plaintiffs'" repeated experiences of inadequate accommodation and incompetent service. I explained that rehabilitation professionals agree with disabled people--to the point that NIDRR sponsored a conference for the sole purpose of generating solutions to this very real problem. I told her that mandating continuing education for community providers and establishing primary care for people with disabilities in rehabilitation hospitals proved to the be the main alternatives.

The doctor remained steadfast that medical services are in no way at fault, ending the discussion with the pronouncement: "I'll tell you the same thing I tell black kids. Get over it!" She gave me a parting warning that I had "shot myself in the foot" by being cranky at the beginning of the interview. Shot my self in the foot? How could that be? Would a "professional" sacrifice objectivity to the impulse to punish an abrasive personality? Apparently she resisted the temptation because I was declared eligible.

I'm now looking for a venue for providing in-service training to SSDI examining physicians AND their reception staffs. Turning ugly experiences into useful correctives is one of my retirement-years responsibilities, I think. I'd be happy to participate personally as a volunteer.

Here's another example. After a lifetime of avoiding committee appointments, I recently agreed to be on the Committee on Disability Issues in Psychology, part of the governing structure of the American Psychological Association. I entered my first meeting with great high hopes and within an hour I thought I'd been caught in a time warp. Because the Committee is located within "The Public Interest Directorate", I thought it was concerned with the impact of psychological issues on the public. The official Committee mission statement reinforced that belief. However, only two of the six Committee members--myself and on other--see the public as the primary beneficiary of Committee efforts. The others see disabled members of the APA as the main targets.

People lucky enough to have PhDs and the ability to pay APA dues don't push my "help" button like people who have equal potential but are trapped in an SSI lifestyle....so drained by its endless obstacle course that they can't escape. The other members either don't know about this greater need or don't care.

We two "radicals" want to include al disabilities under our Committee's umbrella. The others want people concerned with disabilities resulting from mental illnesses rather than physical causes to go form their own committee. Out in the real world, independent-living and disability-rights leadership passed this evolutionary milestone more than a decade ago. The two of us feel like a pretty helpless minority at the moment. I thought about resigning, but decided the more responsible thing to do is hang in there and seek ways to nudge the Committee into the present decade.

The Biggest Responsibility of All

I see life goals as falling into three main categories" goals of doing whatever it is you want to DO, goals of getting whatever you want to HAVE, and goals related to being the kind of person

you want to BE. For 20 pages now I've focused on DOING certain actions in recompense for having received what I needed to HAVE. The responsibilities I described earlier for putting out wholesome attitudes straddle a line between the realms of DOING and BEING. I want to end with some thoughts on pure BEING, so to speak.

What I end up being in this life may affect more than just myself and may do it in a more direct way than through my character shaping my behavior. If so, this creates a set of responsibilities deeper than those imagined by religious moralists and philosophical ethicists. At a concrete level, I know a secret most of you don't know. You may BELIEVE it as an abstract idea, a principle, but only if you're disabled as I am, in one way or another, can you KNOW. I feel one of my main responsibilities is to convey this secret to those who will not experience it directly, in a way that will make it as real to them as it can be. Here it is. Most of you think you need to be happy, you don't.

You already knew that, right? Bullshit. Even I only know it in isolated moments. When I see another car veering toward us on the freeway and think a crash and further disablement might me at hand my insides say "NO! I've adjusted to this much disability but no more!" I've had moments of feeling "I could handle it if I lost even the limited mobility I've got" in the presence of Ed Roberts, who was considerably more paralyzed than I am. It was nothing he said. It was his eyes that said, "I'm having a ball." Ed had more than the usual frustration, anger and despair, but more and more as his life progressed, he smiled through his eyes. Actually, he chuckled through his eyes. When he died, he wasn't ready for it because he was still having fun. (Don't ask how I know. That's for a different time and venue, along with other moments I've had of knowing that more disablement--or anything else that could happen to me--would be okay. The closest thing I'll come to talking about matters that cause modern brains to go into seizure activity is what follows, my last shot on disabled-person responsibilities.)

I think that what I think and feel are not nearly as personal and private as we modernists believe. I think my every thought and emotion goes into the mass consciousness where it affects every member of our species directly and all other species indirectly through our collective behavior. It doesn't matter whether others can decode the content, as putative "psychics" sometimes seem able to do. Others will be affected by it, with or without their awareness, because they cannot avoid "breathing" in whatever consciousness exists on the mental-emotional plane, any more than they can avoid breathing air on the physical plane.

I think the Hitlers and teenage killers and other folks who do what is barely imaginable to most of us are less generators of evil than human aneurysms. They are weak spots in the human fabric through which the collective hates and rages generated by all of us can erupt. And all of us, ALL of us, contribute to the fire that feeds those firestorms. Given this belief system, its incumbent on me to monitor what I think and feel in order to minimize my contributions to the volume of resentments and hostilities and disappointments that occasionally erupt through infantile souls who can't resist the incredible pressures exerted by the mass consciousness.

As far as I know, the only way to do this is to get rid of such thoughts and feelings because repressing or suppressing them doesn't work. Again, as far as I know, the only way to get rid of them is to first acknowledge them; and then use whichever methods of psychology, philosophy or religion best suit your personality in order to purge them and purify your consciousness. In the present context, the focus would be on disability-related emotions. For example, I'm working on raw material provided by the situations described earlier in this paper and the righteous indignation I felt.

To reiterate: in view of my metaphysical belief system, I don't just owe this effort toward personal evolution to myself, I owe it to humanity and all Life. Disability is by no means something I must simply overcome; its my honored teacher. It's taught me that I can do nicely without being able to dance or reach things or go to the bathroom without help. Its taught me I can live well without being physically independent enough to survive without the good will of at least a few other humans. It's kept me from frittering away my life with the pleasant physical distractions I was into before I got polio. It's taught me laser-like focusing of attention.

I could go on as long as life goes on but I won't. I expect to keep on carrying out my felt responsibilities to purge self-indulgent impulses to lapse into indignation, and to purify my automatic (or "sub-") consciousness until all I deposit in the mass consciousness bank is joy. My observable behavior may not change much. My responsibility is to learn to bypass that interim stage of angry condemnation of events or people, and head straight for doing whatever seems right.

This paper is about the meaning of equitable partnership. It is especially powerful because of Dr. Vash's experiences on both sides of the challenge of equity. I have just begun to feel the pull of "being" over "doing", so I have only begun to recognize what Dr. Vash sees so clearly-that we learn responsibility in relationships and the personally and freely accepted obligations that relationships constantly ask of us, not through theapplication of any technique, the attainment of any competency, the compliance with any standard.

"Accountability" in this case is not about the attainment of particular outcomes. Rather it is the shared commitment of a professional and a person with a disability to find the best in themselves and make use of that best toward genuine goals (not "compliant" ones). Genuine goals are about dreams. They are not realistic. Responsibility is about committed struggle to dreams. It is not about success. *Rehabilitation is adult adventure.*

An adult adventure is the inside experience of what we watch from the outside as children. In adult adventures, no one knows how the quest will end. Sometimes it ends in tragedy. Good friends die along the way. People try their best, but it doesn't work out. Other times, it does work out, but the end isn't what anybody planned. It may even be that some outcome that seemed absolutely useless at the beginning becomes the most treasured end of all. Much of the "real" purpose of the quest isn't revealed until long after the end of the quest has apparently occurred; in lessons passed on to others, in new relationships, in learning about one's own self.

Anything that trivializes such an adventure, or turns it into a manipulative game, by either member of the partnership, destroys equity and the relationship necessary to true responsibility. Such a "bureacratization" of the human quest is a betrayal in every sense of the word. In this sense, the failure of accountability is the loss of soul (burnout?, cynicism?).

Norman G. DeLisle, Jr.

As an unapologetic, but admittedly amateur, empiricist and one prone to quantitative "accountability" and the objective, rather than to the qualitative "responsibility" and the subjective, I was more than somewhat challenged by Carolyn Vash's paper. (As an aside, I won't commit myself as to "scientific materialism" because I'm not sure what the term means—although, I suspect, it is not a compliment!)

In the section of the paper entitled, "The Early Years," Dr. Vash recognizes her mother and Dr. Russell for the spirit of "Damn the rules—we'll do what's RIGHT." Indeed, her mother and Dr. Russell were acting in an accountable and responsible manner in pressing the hospital to simply do the right thing.

On the other hand, was the state vocational rehabilitation agency being accountable when it twice rejected Dr. Vash's career aspirations? A good question—one that torments every responsible state vocational rehabilitation counselor, especially upon meeting a former client who soared well beyond the "realistic" but negative eligibility decision or the individualized rehabilitation plan objective. It is in this context, of course, that Dr. Vash is absolutely correct in placing primacy upon the spiritual, the inner life, the imagination—what the empiricists would term "motivation."

To return to the objective-versus-subjective debate, I would hail Dr. Vash's observation that "it's reality, not some ideal, that we must adapt to in our own lives." I would modestly observe that accountability in today's world of rehabilitation service is one of those realities to which we must adapt. Consumers, public and private purchasers, the tax-paying public, rehabilitation professional groups, and providers are coming to expect that the individual professional and the provider organization is to be responsible and accountable for their performance.

In closing, I would note that while our belief systems may differ (I'm a modernist and she's a post-modernist), we are in agreement when she concludes her paper by stating that we need to "bypass the interim state of angry condemnation of events or people and head straight for doing whatever seems right." I would respectfully paraphrase Dr. Vash and say that we must , as a professional field, now bypass the excuses and rationalizations and head straight for doing what is accountable.

Donald E. Galvin, Ph.D.

Dr. Vash, in her paper, speaks to the responsibility of people with disabilities to participate in their own rehabilitation and describes the events in her life where the system of rehabilitation either helped or failed her. Interesting to note, is that the system, even when it failed, did not hinder her progress towards her goals and career development. The point in Dr. Vash's paper, which struck me, is that of the weakness in the competency area for counselors in recognizing entrepreneurial and artistic careers as valid choices for people with disabilities. The V.R. system is designed to produce "closures" (accountability) as it relates to a weekly salary, a certain number of hours worked, and benefits received by the persons they serve. Both in entrepreneurial and artistic careers, these criteria are difficult to meet. Not only must we train counselors (and the community providers whose services they purchase) to value these career choices, we must also change the standards by which we judge career success. Can career success be happiness and satisfaction with daily work or must it be $200 per week at 30 hours with free uniforms? What an opportunity for placement staff to think outside of the standard jobs and really look at consumer choice and satisfaction! I couldn't agree more with Dr. Vash; these careers may be the perfect match for people who don't fit into the neat vocationally appropriate boxes we have so perfectly established. Not only are entrepreneurial careers appropriate options for people with disabilities, but they are also the norm in a society which has downsized itself out of typical middle management jobs and for whom entrepreneurial careers have become the norm, not the exception.

It would seem that, in order to serve people effectively, we, as Dr. Vash propos-

es and reinforces through her life experiences, must move to an inclusive career development process for the people we serve, providing them with a wide range of career options that are flexible and ever changing. And we must provide flexibility in terms of outcome measures using, as Dr. Vash states, "rules as soft guidelines."

Beth Robertson

1. Recommendations/implications that would enhance service delivery:

There was agreement in the group that more consumer input is needed to assure the "continuous improvement" of the State/Federal Vocational Rehabilitation (V.R.) program. Concern was expressed that individuals with disabilities from whom feedback has traditionally been obtained via advisory councils and other means have not been representative of the "typical" V.R. consumer. There is a need to obtain recommendations and input from the "forgotten" consumers who may not have successfully completed the V.R. process.

- To better capture the viewpoints of those consumers so they can have greater influence on V.R. programs and policies, a number of potential approaches were suggested, as follows. All proposed approaches should be used to focus on quality improvement of V.R. programs, rather than solely for evaluation purposes

- Improvement of the written survey instruments used at the local V.R. office level to obtain corrective feedback from consumers.

- Implementation of telephone "exit and follow-up interviews" with randomly selected consumers terminating V.R. services regardless of whether an employment outcome was achieved.

- Formation of a consumer advisory body/focus group at the district office level via random selection from recently closed V.R. cases. These consumers would be asked to meet with management and counselors to provide feedback on what went well, what didn't, problems they experienced with the V.R. system, etc.

- Development/utilization of a written survey instrument to assess consumers' views on vendors from whom they received services. This information could be compiled and used to aid other consumers in making informed decisions about vendor selection.

- Organize and actively recruit for a series of public forums at local V.R. office level to be held throughout the year. Using a small group discussion model, focus on a variety of issues in each meeting, such as the V.R. program itself, assistive technology, transportation, housing, community supports, etc. These meetings could be sponsored by the V.R. program or by a consortium of governmental programs (Community Mental Health, Workforce Development Boards, VA, etc.).

- Conduct consumer group orientations at time of application for services which focus on the responsibilities of consumers in the V.R. process. Provide clear expectations as to how the individual will be expected to play the primary role in developing their rehabilitation program, make decisions/choices about services they need and vendors to provide those services. Be realistic with consumers about funding limitations.

- Foster/encourage continuation of the orientation group as a "support group" for consumers as they move through the V.R. process.

2. Recommendations forprogram development:

Program changes are expected to issue from the approaches suggested under Question #1 and from the demonstration projects recommended under Question #4.

3. Recommendations/implications for education and training:

In counselor training, more emphasis should be placed on the counselor's primary role as an "expert consultant" to the person with a disability. This needs to be the focus at not only the graduate school (pre-service) level, but for in-service and continuing education training (retraining) of V.R. counselors. Specific techniques should be taught which will help counselors foster individual consumer independence and informed decision making.

- District (local) offices should designate one staff person to conduct educational programs for consumers on making informed choices. More in-depth training should be provided for this staff person on this process.

- District offices should partner with local community/disability organizations to encourage them to provide similar training to their members with the goal of encouraging more consumer involvement/participation in V.R. program planning and improvement.

4. Recommendations/implications for needed research:

All suggestions made under Question #1 on enhancing service delivery through improved consumer involvement should be viewed as demonstration research projects. The projects should be piloted, assessed and jointly funded through the Rehabilitation Services Administration (RSA) and National Institute for Disability and Rehabilitation Research (NIDRR).

Fully disseminate results/outcomes from the on-going "Choice" demonstration projects operating in different states. Regional discussion groups should be formed

to learn what to avoid and/or emulate from these projects based on their outcomes. Funding for these discussion groups should come from RSA.

- Establishment of an RSA position at the regional level to liaison with state V.R. agencies to collect "best practices" and regionally sponsored research results for dissemination to others in the region. The position should be jointly funded by NIDRR and RSA. Information obtained can be utilized to formulate training required to address identified needs and implement "best practices" from other states.

RSA and NIDRR provide funding for a research component which state programs can include as a part of their in-service training plan. In-service training funds can be used for the

research component, thereby linking training and research. Program changes are expected to issue from the approaches suggested under Question #1 and from the demonstration projects recommended under Question #4.

5. Recommendations/implications for policy (Legislation-Federal, State,Local):

Identify and resolve any barriers at the Federal and state levels that prevent joint RSA/NIDRR cooperation for research and training.

Legislatively mandate that RSA/NIDRR develop a plan for joint funding of research, demonstration, dissemination and utilization activities and projects.

Legislatively require that randomly selected V.R. consumers who have exited the V.R. System be appointed to serve on the State Rehabilitation Advisory Council so consumer populations are mirrored on the Council.

- Jan Skinner

Practitioner Accountability: Professional, Credentials and Regulations

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Accountability for services rendered by rehabilitation practitioners to clients or consumers of vocational rehabilitation services has been a much discussed topic over the years. Accountability, as defined by Webster (1998), means "the quality or state of being accountable; an obligation or willingness to accept responsibility or to account for ones actions" (p.8). In the provision of rehabilitation services, accountability appears very closely aligned with contemporary concepts of professional competence, ethical behavior, and professional responsibilities in the delivery of services to persons with disabilities.

In fact, one might argue that given the types of clients or consumers served through rehabilitation efforts, that issues of accountability are of particular importance. For example, Tarvydas (1997) has indicated that the sociopolitical history of rehabilitation has clearly demonstrated that clients engaged in the rehabilitation process must often deal with social, political, and legal oppression, and therefore particularly need solution-focused, respectful, nonexploitative, empowering, and ethical relationships with service providers. All providers of services in rehabilitation according to Tarvydas (1997) need to heed the caution embodied in the words of historical figure Samual Johnson, who indicated that "integrity without knowledge is weak and useless and knowledge without integrity is dangerous and dreadful" (p.72).

To address these concerns and others, professionalization movements began in earnest within rehabilitation in the mid 1950's to ensure the competency of practitioners in the ethical delivery of services to persons with disabilities. This was particularly true for those practitioners who were rehabilitation counselors. While the occupational status of rehabilitation counseling was established in the 1920's (Smith Fess Act, 1920), it was not until the mid 1950's, with the passage of the 1954 Vocational Rehabilitation Act Amendments, that the discipline embarked on a series of significant ongoing developments (e.g., pre-service education, professional associations, code of ethics, regulation of practice) that have lead over time to the professionalization of practice in rehabilitation counseling in this country. Although initially a very heterogeneous group of practitioners in terms of educational background and professional competencies, rehabilitation counselors today, as a result of the professionalization process over the past 45 years, represent a group of professionals with a much higher degree of commonalty in relation to pre-service preparation, practice and professional identity, than at any previous time in our professional history (Leahy, 1997).

Unfortunately, even with the advances made in the professionalization of practice, not all rehabilitation counselors who practice in the public and private sectors of rehabilitation today are considered part of the profession or regulated (certification and/or licensure) in relation to individual practices. In addition, there are other practitioners who provide critically important services (e.g., case management, job placement, vocational evaluation, job coaching) to individuals with disabilities, who do not have the relevant pre-service education and are not held accountable through the regulatory mechanisms of any established independent professional body.

Given these general concerns, the purpose of this paper is to review those elements of the rehabilitation counseling profession and other related disciplines, which provide the basis for professional accountability for practitioners providing services to persons with disabilities in today's rehabilitation, health and human services environments. Particular attention will be devoted to the scope and research-based foundation of practice, ethical guidelines, pre-service and continuing education, and the regulation of professional practice (certification and licensure). In addition, specific issues related to the improvement of accountability for professionals providing services will be reviewed and discussed in relation to the critical need for future developments in these areas.

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Practice Settings and Populations

One of the most consistent trends we have witnessed over the years in rehabilitation has been the ever expansion of service delivery settings and populations receiving vocational rehabilitation services. While we generally view the primary practice settings for rehabilitation counselors as the public (state-federal program), private for profit (e.g., workers' compensation, insurance programs), and private nonprofit (e.g., rehabilitation centers, community-based rehabilitation organizations), a number of non-traditional settings have emerged in recent times as a result of legislation and other social and economic factors. For example, new practice settings have emerged to include employee assistance programs, disability prevention and management programs within employer-based settings, school-based transition programs, mental health programs, university-based services for students with disabilities, and hospitals and clinics (Leahy & Szymanski, 1995).

Given these trends, what effect has this lateral expansion of service delivery into new settings had on the issue of practitioner accountability in the delivery of services to people with disabilities? One could easily argue that these changes have further highlighted the need for individual practitioner service delivery standards, ethical codes, and regulation, given the potential absence of specific agency guidelines within these settings, and the lack of practitioners cohorts with similar professional backgrounds . In other words, in the absence of federal guidelines (e.g., RSA) and accreditation standards and requirements (e.g., CARF standards) there is even a greater need for individual practitioner competence, professional identity, accountability and regulation of practice.

Furthermore, practice within all settings appears to becoming more and more complex, with a variety of additional stakeholders involved in the individual process (e.g., employers, insurance carriers, family members, guardians, advocates, attorney's, other service providers) in addition to the counselor and client relationship. This requires the ability to deal more effectively with various interests, while keeping the welfare of the client central to the process. Thus again, emphasizing the need for highly qualified professionals, grounded in ethical standards and accountable to the client and the discipline for their professional behavior.

In addition to expanded settings, the populations served by rehabilitation counselors and other related disciplines has also evolved over time in response to medical and technological advances, legislative mandates, and changes in public policy. In today's service delivery environments, rehabilitation counselors not only serve individuals with physical disabilities, but those with severe developmental, cognitive, emotional, and addiction disabilities, among others, depending on the employment setting in which they practice. These changes have had a direct effect on the type and level of knowledge and skills required to effectively provide services to these populations and the resultant requirement that pre-service, in-service and continuing education be accountable to train students and current professionals to effectively serve these more complex populations and problems.

Scope of Practice

As indicated earlier, as rehabilitation efforts have expanded and populations served have increased, the fundamental role of the rehabilitation counselor has evolved as well (Jaques, 1970; Rubin & Roessler, 1995; Wright, 1980), with the subsequent functions and required knowledge and skill competencies of the rehabilitation counselor expanding exponentially. However, regardless of their employment setting and client population, most rehabilitation counselors: (a) assess client needs, (b) work with the client to develop goals and individualized plans to meet identified needs, and (c) provide or arrange for the therapeutic services and interventions (e.g., psychological, medical, social, behavioral) needed by the client, including job placement and follow-up services.

In order for practitioners to be held accountable, the parameters and goals of practice must be specified. The official scope of practice statement, adopted by all relevant professional and regulatory bodies in rehabilitation counseling, reads as follows.

"Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions. The specific techniques and modalities utilized within this rehabilitation counseling process may include, but are not limited to: assessment and appraisal; diagnosis and treatment planning; career (vocational) counseling; individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability; case management, referral, and service coordination; program evaluation and research; interventions to remove environmental, employment and attitudinal barriers; consultation services among multiple parties and regulatory systems; job analysis, job development, and placement services, including assistance with employment and job accommodations; and the provision of consultation about, and access to, rehabilitation technology" (CRCC, 1994, pp. 1-2).

Research-Based Foundation - Knowledge and Skill Competencies

In addition to the specification of the scope of practice, underlying the practice of any profession or professional specialty area is the delineation of specific knowledge and skill requirements necessary for effective service delivery. Job analysis, role and function, professional competency, critical incident, and knowledge validation research, are all terms that describe a process whereby the professional practice of rehabilitation counseling has been systematically studied to identify and describe important functions and tasks or knowledge and skills associated with the effective delivery of services to individuals with disabilities, that individual practitioners are accountable for in the delivery of services within their scope of practice (Leahy, 1997). Over the past 45 years, an extensive body of knowledge has been acquired through these various research methods that has empirically identified the specific competencies and job functions important to the practice of rehabilitation counseling (e.g.,

Berven, 1979; Emener & Rubin, 1980; Harrison & Lee, 1979; Jaques, 1959; Leahy, Shapson & Wright, 1987; Leahy, Szymanski & Linkowski, 1993; Muthard & Salomone, 1969; Rubin, Matkin, Ashley, Beardsley, May, Onstott, & Pucket, 1984; Wright & Fraser, 1975).

Although role and function approaches generally provide an empirically derived description of the functions and tasks associated with the role, the knowledge required to perform these functions is more indirectly assessed and inferred on the basis of the described functions and tasks. Roessler and Rubin (1992) in their review of recent major studies (Emener & Rubin, 1980; Leahy, et al., 1987; Rubin et al., 1984) concluded that rehabilitation counselors have a diverse role requiring many skills if they are to effectively assist individuals with disabilities improve the quality of their lives. They also concluded upon review of the various studies that the role of the rehabilitation counselor can be fundamentally described as encompassing the following functions or job task areas: (a) assessment, (b) affective counseling, (c) vocational counseling, (d) case management, and (e) job placement.

Conversely, knowledge validation and professional competency approaches provide an empirically derived description of the knowledge and skills associated with a particular role, but the actual functions and tasks are more indirectly assessed and inferred on the basis of the knowledge and skills needed by an individual in order to practice. Recent research by Leahy et al. (1993) provided empirical support that the following ten knowledge domains represent the core knowledge and skill requirements of rehabilitation counselors: (1) vocational counseling and consultation, (2) medical and psychological, (3) individual and group counseling, (4) program evaluation and research, (5) case management and service coordination, (6) family, gender and multicultural issues, (7) foundations of rehabilitation, (8) workers' compensation, (9) environmental and attitudinal barriers, and (10) assessment. A complete listing of the knowledge domains and sub domains from the ongoing CRCC/CORE Knowledge Validation Study is provided in Appendix A, at the end of this paper.

In terms of research utilization and application, these empirically derived descriptions of the rehabilitation counselors role, function and required knowledge and skill competencies have assisted the profession in a number of important ways that relate to accountability. First, they have helped define the professional identity of the rehabilitation counselor by empirically defining the uniqueness of the profession and by providing evidence in support of the construct validity of its knowledge base. Secondly, the descriptions have been extensively used in the development of pre-service educational curricula in order to provide graduate training in areas of knowledge and skill critical to the practice of rehabilitation counseling across major employment settings. Third, the long-standing emphasis on a research-based foundation to practice has greatly contributed to the rehabilitation counseling profession's leadership role in the establishment and ongoing refinement of graduate educational program accreditation, through the Council on Rehabilitation Education (CORE), and individual practitioner certification, through the Commission on Rehabilitation Counselor Certification (CRCC) (Leahy, 1997). Moreover, this research-based foundation provides a level of ibility for the profession, by assuring that those knowledge and skill areas required in practice are reflected in pre-service educational programs, academic program accreditation standards, and individual practitioner certification standards.

Ethical Guidelines

When we consider practitioner accountability, ethical behavior and the consistency of practice with established ethical codes appears central to any such discussion. Rothman (1987) has indicated that ethical codes are characteristic of professions and "define the responsibilities of the members of the profession, to clients, to society, and to colleagues" (p.71). In 1987, the rehabilitation counseling professional associations (American Rehabilitation Counseling Association, and the National Rehabilitation Counseling Association) and certification body (CRCC) adopted and implemented a Code of Professional Ethics for Rehabilitation Counselors and a disciplinary procedure to address ethical complaints received by the CRCC in relation to certified counselors (Patterson, 1987).

According to Tarvydas (1997), this code, which has now been in operation for over 10 years, consists of canons, which are "general standards of an aspirational and inspirational nature reflecting the fundamental spirit of caring and respect that professional share. They are maxims which serve as models of exemplary professional conduct" (CRCC, Preamble, P.2). The cannons address general moral and legal standards, the counselor-client relationship, client advocacy, professional activities, public statement/fees, confidentiality, assessment, research activities, competence, and use of the CRC credential. Supplementing each cannon for clarification and enforcement are rules that are "more exacting standards that provide guidance in specific circumstances" (CRCC, Preamble, p.2).

While the Code of Professional Ethics for Rehabilitation Counselors provides for explicit guidance in relation to professional behavior and disciplinary procedures for acting on ethical complaints, one must ask the question, who does the code actually cover in practice? Unfortunately, unless the practitioner is a Certified Rehabilitation Counselor (CRC) he or she is not accountable to the code nor to the disciplinary procedure designed to enforce it. This then underscores an earlier point made in this paper, that is, if someone is not required to be part of the profession (e.g., CRC) to practice rehabilitation counseling, then he or she does not fall within the boundaries of ethical accountability as specified by the regulatory body (CRCC) of the profession. It should be noted, however, that there are additional regulatory bodies that provide certification (covered later in this paper) for rehabilitation counselors and related practitioners, and state licensure statutes, that like CRCC, also require adherence and accountability to codes of professional behavior and conduct, as long as the rehabilitation counselor or rehabilitation practitioner is a certified or licensed professional.

Pre-service and Continuing Education

Although the occupational status of rehabilitation counseling was established in the early 1920's, by the 1940's only three universities (New York, Ohio State, and Wayne State) had developed graduate training programs to address these training needs (Jenkins, et al., 1992). However, by the early 1950's it was becom-

ing increasing clear to many that more graduate training programs in rehabilitation counseling were required in order to train counselors for this increasingly complex role within vocational rehabilitation. Due in large part to the wisdom and foresight of Mary Switzer, in 1954, with the passage of the Vocational Rehabilitation Act Amendments, federal grant support was provided for the first time to universities and colleges to develop graduate pre-service training programs to prepare rehabilitation counselors for employment in the public and private nonprofit rehabilitation sectors. This federal training support, which continues to this day, accelerated the design and development of graduate training in rehabilitation counseling in this country and can be viewed as the beginning of the professionalization process for the formal discipline of rehabilitation counseling (Leahy & Szymanski, 1995).

With the expansion of rehabilitation counselor education programs in colleges and universities in the late 1950's and 1960's, there was a developing need to devise a mechanism to standardize and accredit these training programs in order to assure a level of accountability in relation to the curriculum content emphasized. In 1972, the Council on Rehabilitation Education (CORE) was established as the national accreditation body for rehabilitation counselor education programs "to promote the effective delivery of rehabilitation services to individuals with disabilities by promoting and fostering continuing review and improvement of master's degree level programs" (CORE, 1991, p. 2). Research conducted at the University of Wisconsin laid the foundation for a multi-stakeholder program evaluation process, which was recognized in 1975 by the National Commission on Accrediting, a predecessor of the Council on Postsecondary Accreditation (COPA) and is still in use today (Linkowski & Szymanski, 1993). Today, there are over 80 accredited master's degree educational programs in rehabilitation counseling in the United States.

As the trends mentioned earlier in this paper regarding the lateral expansion of the profession into new practice settings and the changing client population began to impact the field, pre-service education programs and CORE were challenged to address these new knowledge and skill requirements in order to prepare students for the wide ranging demands of professional practice across all primary employment settings. In response to these developing issues, large scale national research projects were designed and implemented to provide data to guide pre-service curriculum and standard setting decisions (e.g., Leahy, Szymanski & Linkowski, 1993). These challenges obviously have continued. The need for academic programs and the standards that guide the accreditation of academic programs to be accountable to the realities of practice in the various settings in which rehabilitation counselors practice remains one of the most critical and challenging aspects of rehabilitation education, as it strives to prepare the next generation of rehabilitation counselors.

In addition to the challenges posed by the content of the basic pre-service curriculum, educational programs are currently dealing with a variety of new issues including: new content and credit hour requirements posed by state counselor licensure statutes (e.g., the 60 hour program); the need to make programs as accessible as possible through distance education methodologies; the need for specialized study (e.g., specialization) beyond the generic requirements (CORE); and, limited institutional resources to expand programs to meet the increasing need for pre-service education within the field.

Following graduate level pre-service education, practicing rehabilitation counselors need to continue their professional development to maintain and upgrade knowledge and skills associated with the delivery of rehabilitation counseling services to persons with disabilities. For example, Certified Rehabilitation Counselors (CRCs) are required to obtain a minimum of 100 hours of relevant continuing education during their five-year certification period. With the rapid pace of change in the field and the continual dissemination of new knowledge and expanded skills associated with practice, the rehabilitation counselor needs be aware of continuing educational opportunities available to them. Although there are numerous organizations and groups that provide this type of training, the primary sources and sponsors of continuing education for the rehabilitation counselor are the professional organizations (e.g., ARCA, NRCA), the Regional Rehabilitation Continuing Educational Programs (RRCEPS), Research and Training Centers, and university-based continuing educational programs.

However, with the ever increasing demands placed on pre-service education, many over the years have argued the need for a comprehensive system of education that links pre-service, in-service and continuing education in order to develop a strong foundational set of professional competencies at the pre-service level, and then systematic development of more advanced practitioner skills through in-service and continuing education. In reality, these educational systems remain quite separate at present. Clearly, we need to do more to marshal our limited resources in order to build and sustain an accountable, developmental model of education, that is continuously available to practitioners as they advance their individual competency levels.

Regulation and Credentials

Regulation of practice through professional certification and licensure have been identified as key elements of professions (Rothman, 1987) and central to the issue of practitioner accountability. Over the past 25 years there have been increased efforts to develop professional credentials, particularly certification and licensure, to identify professionals who have met educational, work experience, and knowledge standards of their respective profession or disciplines (e.g., CRC, CDMS, CCM, LPC). While these certification and licensure efforts have developed systematically in response to a primary need to protect the public in relation to qualified providers, they have also created a great deal of confusion among practitioners, other related professional groups, consumers, payors, legislators, and other stakeholders in the health care and rehabilitation process.

Forms of Credentials

Credentialing is the process of granting an individual practitioner a credential that designates that professional as attaining a specified level of competence in a subject or area (Fabrey, 1996). The three generally accepted forms of credentials include licensure, certification, and registration. Among the three credentials, licensure is clearly the most restrictive and refers to the mandatory government (state level) requirement necessary to practice in a

particular profession or occupation. Licensure includes both practice and title protections which mean that only licensed practitioners are permitted to practice and use a particular title (Fabrey, 1996). In rehabilitation, the most frequently held licensure designation has been the Licensed Professional Counselor (LPC) credential.

The second form of credentialing is the granting of certification. This process is usually voluntary, and instituted by a non-governmental body, where individuals are certified as possessing specific (advanced) knowledge in a particular area. Similar to licensure, the certification process normally requires an assessment of knowledge and an evaluation of education and/or work experience. In some cases, and particularly true with rehabilitation counselors, individuals seeking national certification already hold or will attain specific licenses (LPC) at the state level. Certification implies a title protection (e.g., CRC, CCM, CDMS, CVE) but unlike licensure, it does not protect practice unless it is used by employers, payors, and governmental agencies as a mandatory requirement to deliver services. While the ultimate intent of licensure is to directly protect the public from incompetent practitioners who do not possess the appropriate level of education, work experience and knowledge (determined by the profession), the general intent of certification is to inform the public that individuals who hold certification have demonstrated a specific level of knowledge and skill. The only method of direct public protection that certification can offer is through the enforcement of its ethical code (Fabrey, 1996).

Finally, registration is the third recognized form of credentialing. This credential is the least restrictive of the three and is generally used in situations where protection of the public is not critical. The granting of registration may imply the recognition of certain types of training and education related to a set of knowledge and skills.

Certification in Rehabilitation

In our field, the Certified Rehabilitation Counselor (CRC) credentialing process is the oldest, and most established certification process in the counseling and rehabilitation professions. The purpose of certification is to ensure that the professionals engaged in rehabilitation counseling are of good moral character and possess at least an acceptable minimum level of knowledge, as determined by the Commission, with regard to the practice of their profession. The existence of such standards is considered to be in the best interests of consumers of rehabilitation counseling services and the general public. From a historical perspective, the CRC credentialing program was an outgrowth of the professional concerns of the American Rehabilitation Counseling Association (ARCA) and the National Rehabilitation Counseling Association (NRCA).

Since the inception of the credential and the subsequent development of the Commission on Rehabilitation Counselor Certification (CRCC) in 1973, over 23,000 professionals have participated in the certification process. Today there are over 14,000 CRCs practicing in the United States and several foreign countries (Leahy & Holt, 1993). Certification standards and examination content for the CRC have been empirically validated through ongoing research efforts throughout the 25 year history of the Commission, and are currently regularly examined as part of the ongoing CORE/CRCC Knowledge Validation Study (Leahy, Szymanski & Linkowski, 1993). These standards represent the level of education, experience and knowledge (see Appendix A) required of rehabilitation counselors, as determined by the profession, to provide services to individuals with disabilities across all practice settings.

In addition to the CRC credential, there area number of related certification credentials that rehabilitation practitioners may hold that deserve mention at this time. The first of these credentials is the Certified Disability Management Specialist (CDMS), which has been in existence since around 1983 (formerly known as the Certified Insurance Rehabilitation Specialist, CIRS). This credential was developed for various professionals delivering direct rehabilitation services to individuals receiving benefits from disability compensation programs. The second of these is the Certified Vocational Evaluation (CVE) credential, which was developed to certify individual competency related to the provision of vocational evaluation services. Finally, and the newest of all the credentials is the Certified Case Manager (CCM). This credential, which was developed in 1993, was designed around the process of case management as practiced by many different professionals in a variety of health care and rehabilitation settings.

So given this basic information, how do we distinguish between these related credentials that were designed to certify professionals who practice in the rehabilitation and health care arenas? One of the most basic distinctions among the four credentials noted above relates to whom the credential was intended to be for and what formed the primary basis from which the credential was organized. For example, the CRC credential is intended for appropriately trained rehabilitation counselors and the credential is exclusively organized around the role and function of the rehabilitation counselor and the required levels of knowledge and skill required to practice in a variety of rehabilitation and health care settings. This type of professional identity and organization is also true for the CVE where the credential is exclusively organized around the role and function of the vocational evaluator. However, the next two are quite different. The CDMS credential is intended for a variety of qualified professionals and is organized around the required knowledge and skill to provide case management and rehabilitation services to clients served by disability compensation programs. Finally, the CCM credential is intended for a very heterogeneous group of already licensed or certified practitioners who meet the work experience requirements of case management. The credential is organized around the process of case management and the essential knowledge and skills required that are common to the practice of case management in a variety of settings.

Counselor Licensure

In terms of regulation of practice, the most powerful credential is licensure. As differentiated from voluntary national certification, licensure regulates the practice of a profession through specific state legislation. Beginning in 1976, with the passage of the first counselor licensure bill in Virginia there has been a long struggle by advocates of the counselor licensure movement to

enact legislation on a state-by-state basis to protect the title and regulate the practice of counseling. During the past 20 years over 40 states have enacted counselor licensure legislation. The trend has been toward the passage of general practice legislation (which covers various counseling specialty groups) which is consistent with the recommendations of the American Counseling Association's (ACA) Licensure Committee in its 1994 model legislation for licensed professional counselors (Glosoff et al., 1995). Reflecting this trend, the most commonly used title in counselor licensure bills has been that of the Licensed Professional Counselor (LPC).

Counselor licensure legislation has been intended to regulate both the use of the terms by which the statute officially refers to professional counselors as well as to protect the practice of professional counseling as set forth in its definition and scope of practice provisions. This combination of title and practice bill is the most stringent form of credentialing and would prohibit anyone from practicing counseling unless fully qualified regardless of formal title. Title-only legislation the other hand, which has been passed in 24 of the states, prohibits persons from using the specific titles restricted in the bill to those who have met the specified qualifications established by the bill and have achieved licensure. It does not however, restrict persons from providing counseling services if their job titles avoid restricted language. Most title-only legislation was passed to avoid powerful lobbying efforts that would have been mounted to defeat the more restrictive title and practice bills. Clearly this type of legislation was seen as a first stage by counselor licensure advocates in the overall drive toward eventual regulation of practice through future revisions of the initial legislation (Tarvydas & Leahy, 1993).

While there are presently three states who have passed licensure laws specifically covering the rehabilitation counselor (Texas, Louisiana, and Massachusetts) the majority of states have enacted general practice legislation covering all counselors. The professional associations in rehabilitation counseling (ARCA, NRCA and the Alliance for rehabilitation Counseling) have taken the position to strongly advocate for the inclusion of rehabilitation counselors within general counselor state licensure whenever possible. With this in mind, the Licensed Professional Counselor (LPC) designation, combined with certification as a Certified Rehabilitation Counselor (CRC) would represent the appropriate credentials for rehabilitation counselors working with individuals with disabilities, in states with general practice legislation.

Contemporary Issues

In the final section of this paper a number of specific issues related to the improvement of accountability for professionals providing services will be reviewed and discussed in relation to the critical need for future developments in these areas.

Practice Outside the Profession

Over the years, and particularly during the past 20 years there has been a growing expectation among members of the profession, employers and regulatory bodies that rehabilitation counselors who provide services to people with disabilities have the appropriate pre-service education and credentials (certification and licensure) as identified previously. However, even today there are individuals practicing as rehabilitation counselors in both the public and private rehabilitation sectors in this country who do not have this type of pre-service preparation or appropriate credentials. While this heterogeneity in professional background was once thought of as a natural consequence of a quickly expanding field, in more recent years the practice of hiring individuals without appropriate professional training and credentials has been heavily criticized by professional, educational, and regulatory bodies in rehabilitation counseling. One of the key characteristics of any profession, according to Rothman (1987) is regulation of practice. However, individuals who practice rehabilitation counseling outside of the profession are not accountable to or included in such regulation of practice, and are therefore not required to adhere to the profession's code of ethics or accepted standards of practice. While this situation has improved over the years, particularly with the recent advances in public policy regarding qualified providers noted below, it is still unacceptable. It is clear, however, that in the years to come the trend toward professionalization and particularly the movement toward state licensure and certification in this country will make it less likely that an individual will be able to practice as a rehabilitation counselor without appropriate training and credentials.

Recent Policy Changes

Recently, in probably one of the substantive policy advances in the history of the public rehabilitation program in relation qualified providers of services, the Rehabilitation Act Amendments of 1992, provided explicit guidance to the state agencies in terms of personnel requirements that may have a very significant and long lasting effect in relation to professionalism and accountability at the practitioner level. In 1997 these new regulations regarding qualified providers of rehabilitation counseling services were implemented within the public rehabilitation program. In a recent Commissioners Memorandum (CM-98-12), dated May 29, 1998, Fredric Schroeder indicated that:

"Section 101(a)(7) of the Rehabilitation Act Amendments of 1992, commonly referred to as the Comprehensive System of Personnel Development (CSPD), requires State Vocational Rehabilitation (VR) agencies to establish qualified personnel standards for rehabilitation personnel, including VR counselors, that are consistent with any national or State-approved or recognized certification, licensing, or registration that apply to a particular profession. To the extent that a State's existing personnel standards are not based on the highest requirements of the State, the State agency is also required to develop a plan to retrain or hire personnel to meet personnel standards that are based on the highest requirements...The purpose of the CSPD provisions is to ensure the quality of personnel who provide VR services and assist individuals with disabilities to achieve employment outcomes through the VR program" (p.1).

In most situations, according to RSA's interpretation of these provisions, state agencies will be required to upgrade and retain existing personnel to the point at which they would be considered eligible for CRC certification. For new hires this same standard would be used. What this does not mean is that these personnel would be required to be certified. In addition, only academic criteria will be used by the state agency to determine eligibility, not

the typical process of evaluating both academic and work experience, as is the case with CRCC.

So what does this really mean? On the one hand this represents a very positive step forward in relation to upgrading the educational backgrounds of rehabilitation counselors practicing in State agencies throughout this country. On the other hand, while these provisions are viewed as highly constructive, the current interpretation of the provisions as relating to only eligibility and not the attainment of the CRC credential, represents some real limitations in relation to individual practitioner accountability. As indicated previously, certification implies that the practitioner not only have appropriate education, but is able to successfully pass a knowledge exam, adhere and be accountable to the profession's code of ethics in delivering services, and continue the process of professional development while certified through continuing education.

Obviously, this is a watershed development in relation to public policy, even with the limitations noted above, with wide ranging ramifications for the future. For example, by association, these same personnel regulations will be applied at a later date to those providers of services in the private sector, who receive referrals from the public program, thus magnifying the professionalization impact and the educational needs in both practice settings. At the present time, it will be imperative for educational programs and state agencies to work more closely then ever before to address these emerging personnel needs within the public rehabilitation program. Pre-service and continuing education programs are in a position to play a critical and constructive role in developing creative, responsive and educationally sound options for state agencies to utilize in order to comply with the original legislative intent of these provisions.

Clinical Supervision

One area accountability that has yet to be addressed in this paper is that of clinical supervision. Most would agree that a systematic process of clinical supervision for practitioners in the field is valuable for both the validation and resolution of individual case issues and extremely beneficial for individual practitioner professional development. Unfortunately, this area of practice, which is highly related to accountability and professionalism, is woefully lacking in our field. Although there appears to be a sufficient level of administrative supervision being practiced in our various work settings, systematic clinical supervision is rarely a routine aspect of a practitioners daily professional life.

The need to understand effective models of clinical supervision and prepare supervisors in the field for this professional role appears critical to the continued success of our rehabilitation programs and the further development of rehabilitation counselors, particularly in relation to pre-service, certification and licensure requirements, which expect this level of professional accountability. Clearly further research, standard setting (CRCC and CORE), and additional preparation for experienced professionals will be required in order to develop the resources to provide this level of rehabilitation counselor accountability and support in the field.

Expansion of Educational Efforts

Currently there are over 80 CORE accredited graduate degree programs in rehabilitation counseling, numerous other pre-service programs (e.g., Vocational Evaluation, Job Placement, Rehabilitation Services), and a variety of programs offering continuing education to rehabilitation counselors and related personnel in this country. While the general demand for rehabilitation education at the graduate level has been increasing over the years due to certification and licensure requirements, policy advances (CSPD), and other competitive market factors, the resources to provide this type of professional training have not kept pace with the demand.

In addition to the obvious need for a greater financial investment in educational resources (e.g., RSA), many programs throughout the country have began to experiment with various forms and methods of distance education, specifically designed to facilitate access for the student and professional to graduate level and continuing educational programs. While many of these efforts appear quite promising, they should still be viewed as experimental in nature. Clearly, there appears to be certain types of curriculum content that can be delivered to students effectively using technology assisted learning methodologies, and other areas of study and training which are not amenable to these types of formats and approaches. As one might anticipate, distance learning, as an option to the more traditional approach to graduate and continuing education, is appealing to potential students, administrators of agencies, and even educational administrators. However, the field needs to move very thoughtfully in this direction to protect the integrity of our educational programs and the quality of training that our students and professionals receive.

Obviously, additional financial and personnel resources will be required in order to meet these needs though creative innovation and transformations of our more traditional educational approaches. In addition to these resources, we will need to invest in research efforts that will provide empirical guidance in relation to which approaches are productive and which are not. Finally, as more is known, we will need to a provide additional guidance in relation to distance education standards through our accreditation efforts (e.g., CORE).

Conclusion

The issue of practitioner accountability addressed in this paper is clearly central to the individual client - counselor relationship and professionalism in the delivery of rehabilitation services to individuals with disabilities. In addition to agency procedures and organizational standards (e.g., CARF), professionalism and regulation of individual practices, as exemplified through the possession of appropriate pre-service education and credentials (certification and licensure) appear critical to provide overall levels of accountability to the clients served in rehabilitation settings. While there has been very significant progress over the years in these areas, there are still practitioners practicing outside the regulatory boundaries of the profession. We must continue to make progress on this front in the years to come to ensure that practitioners providing services are qualified and accountable. We must also continue our work to further improve our pre-service programs and credetialing mechanisms to provide the level of support

and standards necessary to guide this required level of accountability that clients and consumers of our services deserve.

Appendix A

Knowledge Domains and Subdomains from the CORE/CRCC Knowledge Validation Study (1993)

Knowledge Domain/Subdomain

Vocational Counseling and Consultation Services
- Planning for vocational rehabilitation services
- Vocational implications of various disabilities
- Physical/functional capacities of individual
- Occupational and labor market information
- Job placement strategies
- Client job seeking skills development
- Employer practices affecting return to work
- Job analysis
- Client job retention skill development
- Job modification and restructuring techniques
- Job and employer development
- Theories of career development and work adjustment
- Follow-up and post-employment services
- Accommodation and rehabilitation engineering
- Supported employment services and strategies
- Employer-based disability prevention and management
- Computer applications and technology
- Services to employer organizations

Medical and Psychological Aspects of Disability
- Medical aspects and implications
- Medical terminology
- Psychosocial and cultural impact of disability
- Appropriate medical intervention resources

Individual and Group Counseling
- Individual counseling practices and interventions
- Individual counseling theories
- Behavior and personality theory
- Human growth and potential
- Family counseling theories
- Group counseling practices and interventions
- Group counseling theories

Program Evaluation and Research
- Evaluation procedures for assessing effective services
- Rehabilitation research literature
- Basic research methods
- Design of research projects and needs assessments

Case Management and Service Coordination
- Case management process
- Community resources and services
- Services available for a variety of populations
- Financial resources for rehabilitation services
- Rehabilitation services in diverse settings
- Planning for independent living services
- Organizational structure of the public rehabilitation program
- Organizational structure of nonprofit service delivery system

Family, Gender, and Multicultural Issues
- Societal issues, trends, and developments
- Psychosocial and cultural impact on the family
- Multicultural counseling issues
- Gender issues
- Family counseling practices

Foundations of Rehabilitation Counseling
- Ethical standards for rehabilitation counselors
- Laws affecting individuals with disabilities
- Rehabilitation terminology and concepts
- Philosophical foundations of rehabilitation
- History of rehabilitation

Workers' Compensation
- Workers' compensation law and practices
- Expert testimony
- Organizational structure of the private-for-profit system

Environmental and Attitudinal Barriers
- Attitudinal barriers for individuals with disabilities
- Environmental barriers for individuals with disabilities

Assessment
- Interpretation of assessment results
- Test and evaluation techniques for assessment

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Implications for Training and Development: This discussion is absolutely essential in a climate so highly charged with concern regarding accountability. Every aspect of service delivery ultimately will be reduced to the capacity of the credentialed practitioner to be accountable, effective and professional while providing services. It is equally essential that organizations develop and/or enhance policies which mandate practitioner competencies. In essence, failure to do so not only signals services which may lack quality, but also significantly increases that organization's risk. One cannot fully discuss accountability without discussing risk management.

Therefore, this paper has significant implications for practitioner training and development. I agree with Dr. Leahy that practice is truly becoming more complex and rehabilitation practitioners must aspire for higher qualification. New practice settings are providing new challenges as well as new opportunities for effectiveness.

As the demand for practitioner accountability continues to increase, it is critical that continuing education efforts empower practitioners with knowledge that increases their potential for achievable outcomes. Thus, a practitioner's study of best practices, applied research, national accreditation standards, cultural competency and trends in the field provide a sampling of those areas which may improve the level of functioning of persons served.

Costs associated with staff training/development, associated issues of staff retention, competitive wages, etc., all must be addressed as well in this heightened climate of accountability.

Donald J. Dew

The development of professional standards, primarily through the efforts of the CRCC, has significantly improved the practice of rehabilitation counseling, I have no doubt. However, the emergence of new practice settings, particularly those which are employer-based, poses credentialing, professional practice, and ethical standards challenges which necessitate a broad-based approach in order to assure the accountability of these new practitioners. Specifically, the field of disability management (DM) has shifted the primary focus of service delivery from the individual to the employer.

The provision of effective and efficient DM services clearly benefits employees with disabilities through the timely provision of healthcare services; coordination of return to work efforts between physician, insurer, employer, and employee; and development of appropriate transitional and job modification/accommodation options. But the primary stakeholder in the delivery of DM services is the employer. DM practitioners are increasingly employed by business or are contracted directly by employers (rather than through insurers). This requires that DM professionals develop employer-based skills and deliver services in ways compatible with employers organizational processes which, in turn, necessitate a fundamental change in the relationship between disabled employee and DM provider. In short, DM providers and programs are accountable to the organization of which they are a part.

Employer-based employee assistance programs have faced similar dual accountability issues and the profession continues to seek the proper balance between organizational demands and individual needs. For DM practitioners, the difficulties of defining the limits of organizational and individual accountability are compounded by the hybridization of the field of DM with other related organizational areas such as safety, risk management, benefits administration, and human resources.

A certification process, which focuses primarily on the counselor/client relationship as the domain of practice, does not serve the wider needs of employers in ensuring DM quality. It is suggested that an interdisciplinary certification effort is needed, linking with other certifying bodies such as:

American Compensation Association (Certified Benefits Professional)

Society for Human Resources Management (Professional in Human Resources)

Risk and Insurance Management Association (Accredited Risk Manager)

Bruce G. Flynn

Dr. Leahy's paper examines the elements which provide the basis for accountability in the rehabilitation counseling profession. He reviews the field's scope of practice and the knowledge/skills needed to provide effective counseling services, pre-service and continuing education programs which train counselors, professional codes of ethics which guide behaviors, certification and licensure which establish and monitor adherence to standards of practice. Dr. Leahy proposes ways in which improved accountability can be achieved in the future, such as increasing the number of counselors practicing "within" the field; linking pre-service, in-service and continuing education to provide a comprehensive continuum of training; increasing clinical supervision of practitioners, concurrent with more structured training of those clinical supervisors.

The approaches suggested by Dr. Leahy to improve counselor accountability are excellent and necessary to protect consumers of rehabilitation services. As a practitioner for the last 18 years in both the public and private sectors, I have seen many counselors practicing "outside" of the field. Achieving Certified Rehabilitation Counselor (CRC) or Licensed Professional Counselor (LPC) status is viewed as "optional", with some counselors choosing to obtain one or the other credential or neither of them, citing cost or lack of employer expectation as factors in their decision. The State-Federal V. R. program needs to move to the "next" level in defining "qualified" personnel, requiring that counselors actually obtain CRC and licensure where in place. There is also a need to change "title" licensure to "practice" licensure in those states where legislation protects only the title of "counselor," not the scope of practice. Until

these two steps are accomplished, there will be too many practitioners who will elect to remain "outside" leaving the public and rehabilitation field with no means to hold them accountable to accepted/ expected practices.

Jan Skinner

1. Recommendations/Implications that would enhance service delivery:

The group's recommendations are based on our belief that an increase in professionalism and credentialing, in rehabilitation counseling will increase the quality of services received by people with disabilities in any sector of delivery including public, private non-profit, and private for profit.

It is recommended that:

- Standards be set for practitioners other than Qualified Rehabilitation Counselors that further define their role and scope of practice. These other practitioners include: assistive technology professionals, job developers, rehabilitation engineers, and job coaches and others rehabilitation related disciplines.

- A process for the professional development of current practitioners who find themselves in a position without the benefit of the appropriate education be established. This process would include but not be limited to 1) continued education and 2) clinical supervision.

- The development of cultural competence in service delivery; including bilingual outreach, be emphasized.

- Quality assurance reviews in One Stop Employment Centers be provided which will increase the quality of services to people with disabilities and assure that appropriate services are being provided by Certified Rehabilitation Counselors.

- The assessment of consumer satisfaction currently mandated in the public rehabilitation system also be completed in all services delivery systems, including both private for profit and not-for profit organizations.

- Qualified professionals be utilized in the eligibility process when it is determined that assessment services are not within the scope of practice of the Certified Rehabilitation Counselor (CRC).

- Access to rehabilitation counseling services for people with disabilities who have third party insurance be increased.

Implications include:

- A need to assure that reductions in client service would not occur, in order to make funds available for increased personnel cost including salary, training cost and time away from work setting.

- The loss within state agency systems of highly qualified and experienced Rehabilitation Counselors to other systems.

- The need to address how to retain qualified professionals in all service delivery arenas.

- The recognition that credentialing, especially state practice licensure laws, will provide entry into third party payment systems.

- The expectation that credentialing will also assure that consumers will be able to access the appropriate provider.

- An understanding that licensure precludes unqualified practice, and is good risk management

2. Recommendations for program development:

- Establish systematic clinical supervision as an ongoing professional development mechanism for field staff.

- Advocate the use of and experience with various forms of distance education order to create greater access to pre-service and continuing education programs.

- Use collaboration of groups to increase knowledge for I.P.E. development

- Maintain a commitment to programs that represent and respond to issues of cultural competence.

3. Recommendations/Implications for education and training:

- Given change in current system, maintain a comprehensive review of curriculum for relevancy and inclusion of emerging skill areas.

- Market the field to current staff and possible students.

- Train students in methods of marketing cost benefits and successes of rehabilitation services to employers, insurers, people with disabilities, and family members.

- Experiment with various forms of distance education in order to create greater access to pre-service and continuing education programs.

- Link pre-service with in-service and continuing education to develop a systematic process of development for Rehabilitation Counselors, recognizing that pre-service training alone is not sufficient.

- Bilingual outreach.

- Continued training to expand access through the computer including electronic mail, web sites and the Internet.

- Expand development of assistive technology training. Increase all education and training funding from the Rehabilitation Services Administration (RSA) particularly that related to the Comprehensive System of Personnel Development (CSPD).

4. Recommendations/Implications for needed research:

The following recommendations pertain to research:

- Continue to expand "field based research addressing best practices" to see how these contribute to outcomes. Integrate these findings into education, training and program development.

- Examine the impact of qualified providers, as we define them, on services in various arenas, including Long Term Disability Insurance, Social Security Disability Insurance, Private Insurance and Workers' Compensation.

- Examine the effectiveness of distance learning.

- Examine the effectiveness of continuing education programs.

- Examine the effectiveness of assistive technology.

- Examine salary and benefits, and working environment issues with regard to attracting and retaining qualified rehabilitation professionals and Certified Rehabilitation Counselors.

5. Recommendations/Implications for policy:

The following recommendations will impact policy at the agency level:

- There must be a clear commitment to staff development and training.

- Agencies must set standards which define and differentiate the roles of various rehabilitation practitioners.

- There must be standards, guidelines and the provision of appropriate clinical supervision.

- Policies and standards must be in place to assure cultural competency at both the organizational and at individual levels.

- Adequate money and time must be assured to support necessary training and education.

- Issues of diversity need to be considered and attention should include awareness education, hiring/recruitment of diverse qualified professionals and staff development.

- States and agencies adopt policies to support pay for training and time away from job with a recognition of a shared investment by the employee/student and the employer.

- Advocate for increased internships

The following recommendations will impact policy at the legislative level:

- We recommend that legislation be enacted to establish a practice licensure requirement for counselors.

- The CSPD standard needs to change from an "eligible" to actual attainment of the CRC.

- Continue to refine and validate qualified personnel and competencies associated with effective practice.

6. Other Recommendations:

- It is recommended that there be a comprehensive education of multiple stakeholders including legislators, purchasers of service, and employers regarding:

  - the qualifications and role of the CRC
  - the scope of practice
  - ethical guidelines which are adhered to
  - the delivery systems which can be assessed

It is further recommended that for complaint management, peer review, and dispute resolution be established.

Accreditation as an Accountability Strategy

Donald Galvin

This paper will address the role of national accreditation and its contribution to quality improvement and accountability in rehabilitation. The fundamental premise of this paper is the proposition that accreditation can be a powerful tool for achieving quality in the management of accountable rehabilitation organizations, including quality in the services and supports provided and in the outcomes achieved. Accordingly, accreditation is not an end in itself; rather it is a means to achieve accountability and quality improvement in both management and service delivery.

Following a brief discussion of accountability within the context of accreditation, this paper will proceed to discuss the historical, social, economic, and policy dynamics which impact the accreditation environment. Some of the universal principles, values, and purposes which are at the heart of standards and the accreditation process will be reviewed, followed by a discussion of major trends in accreditation which are being fueled by changes in the organization, delivery, and financing of rehabilitation, health care, and other human services.

Accountability Within the Context of Accreditation

Accountability basically means being responsible for something. In the context of health and rehabilitation, the individual consumer holds a variety of entities accountable. The individual consumer holds his/her employer accountable for purchasing health insurance plans that provide access to needed services. The individual consumer also holds various public and nonprofit agencies responsible for assuring that providers of health care and rehabilitation are accountable for delivering good care. And, finally, the individual consumer holds the health and rehabilitation professional accountable for his/her performance.

Dennis S. O'Leary, M.D., President of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), states:

> In this scheme, the accreditation body is, in essence, a friend of the court. It is the neutral evaluator, which must do a good job, because its continued existence is determined by the reliance of others upon it. So the accrediting body is also an integral of the accountability equation." (May/June, 1997)

Sean Sullivan, President of the National Business Coalition on Health, defines accountability as being responsible for those things over which one has control and a willingness to submit to measures and to explain and communicate results. (1997) From this definition, one may conjecture that the rehabilitation organization may be held accountable for:

- Managing the delivery of care.
- Achieving improved life status among individuals being served.
- Delivering services at a reasonable cost.
- Measuring results.
- Communicating results.

Much along the same lines, Charles G. Ray, Chief Executive Officer of the National Council for Community Behavioral Healthcare, notes that accountability—along with effectiveness, equity, and citizen participation—is at the core of the public debate on health care reform. (1996) In addressing accountability, Ray observes:

> When we are taking tax and public dollars and we are using those dollars to provide care, it is the public's right to have accountability. The public deserves to know how many of those dollars are going to serve human beings and what is a realistic return on investment."

In conclusion, and as noted by Dr. O'Leary, systems of quality assurance, such as accreditation bodies, must also themselves be accountable. Accreditation bodies are accountable to the consumers who receive services from accredited organizations; they are accountable to the purchasers who typically are guided by accreditation in their purchasing decisions; they are also account-

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able to the provider organizations to assure that a high quality professional accreditation is in place. However, first and foremost, the accreditation body is accountable to the public at-large for rendering professional judgments for the protection of the public. Thus, in the largest sense, the accrediting body acts in the public interest to set standards of practice in a field, to evaluate conformance to those standards by organizations in the field, and to communicate that information to interested parties.

A Bit of History and an Acknowledgment

The setting of health and safety standards in the workplace, in public buildings, and among consumer products and professional services was a gradual development over the first half of the 20th century. The social reform, progressive, and professionalization movements early in the century set the stage for the setting of standards, the initiation of regulatory activities by various governmental entities, and—among professional groups—the development of accreditation mechanisms to identify those organizations which met the standards as independently established by the field.

In the United States the public protection role of basic health and safety was largely assumed by government (e.g., food, drugs, mining, air transportation, etc.). The quality assurance role, however, has largely been the responsibility of the private sector via various professional trade groups and associations. The history of the Joint Commission on Accreditation of Healthcare Organizations provides an instructive example.

The American College of Surgeons (ACS) was organized in November of 1912 in an attempt to standardize and organize the practice of surgery. Stimulated by the rapid growth in the number of hospitals established between 1873 and 1909, the ACS adopted a resolution calling for "some system of standardization of hospital work." In 1916 the ACS received a grant from the Carnegie Foundation to develop hospital standards. ACS approached the task by conducting a nationwide survey of hospitals. The results were dismal!

As reported by Timothy Jost in the Boston College Law Review (July, 1983):

> "Of the 671 facilities of over 100 beds surveyed by the American College of Surgeons, only 89 could comply with the requirements. To avoid embarrassment to the prominent hospitals that had failed the standard examination, the list of approved hospitals was burned the night before its scheduled presentation in October 1919."

The growing complexity of hospital care and the growth of the industry quickly overwhelmed the resources of the Hospital Standardization Program which had been established by the American College of Surgeons in the early 1920's.

Following a period of strife and threats to develop separate programs, the American Hospital Association, the American College of Surgeons, the American Medical Association, and the American College of Pathologists agreed to form a "joint commission" for the accreditation of hospitals. The Joint Commission on the Accreditation of Hospitals (JCAH) held its first organizational meeting on December 15, 1951.

With the advent of Medicare in 1965, JCAH was radically changed from a private, voluntary accrediting program to an agency with a major role in public health care regulation and financing. The Medicare bill permitted the Secretary of Health, Education, and Welfare (HEW) to grant "deemed status" to those health care providers to the extent that the Secretary found national accreditation bodies provided reasonable assurances that conditions of participation would be met. That is, such accredited hospitals, nursing homes, and home health agencies would be deemed to meet the quality requirements of Medicare participation. The Medicare statute, as finally enacted, not only required HEW to accept JCAH accreditation as a conclusive determination of hospital quality for participation in Medicare, but prohibited HEW from promulgating standards which exceeded those adopted by JCAH. In sum, the effect of the law was to deny Medicare reimbursement to hospitals that were not accredited by JCAH, and furthermore, assured that the government would not compete with, or trump, JCAH accreditation.

And in Rehabilitation

The key individual responsible for the establishment of a national accreditation system in rehabilitation was none other than Mary E. Switzer, the first administrator of the Social and Rehabilitation Service, who is honored by this Memorial Seminar. During her remarkable tenure as the first Commissioner of the Vocational Rehabilitation Administration (now the Rehabilitation Services Administration), Ms. Switzer aggressively advocated for the establishment of national standards and an accreditation mechanism for the field of rehabilitation. She urged the two major professional associations in the field—the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP)—to come together to establish a common set of standards.

In her typically shrewd and masterful administrative style, Ms. Switzer made it known that if the two organizations could not come together to develop an independent, peer-review-based private sector solution, she was prepared to initiate government standards and requirements. By way of incentive, she also made it known that she was prepared to provide grant funds to facilitate the establishment of such an accreditation system.

In 1966, with funding from the Vocational Rehabilitation Administration, the ARC and NASWHP formed the Commission on Accreditation of Rehabilitation Facilities—now known as CARF . . . the Rehabilitation Accreditation Commission. In addition to ARC and NASWHP, early organizational members of the Commission included Goodwill Industries of America (currently Goodwill Industries International, Inc.) and the National Easter Seal Society for Crippled Children and Adults (currently National Easter Seal Society). Most significantly, during the 1970s and 1980s approximately forty state vocational rehabilitation agencies adopted policies urging or mandating CARF accreditation for organizations serving state agency clients.

These two examples illustrate several common elements—including the leadership role played by professional groups—in the establishment of standards and accreditation processes, the collaboration and interdependence of the private and public sectors which are common in our form of government, and the criti-

cal role of reimbursement as a tangible incentive to promote participation and compliance.

Accountability as Rediscovered in the 1990s

Although accountability as an expression of responsibility is not a new initiative, it is fair to say that it is a powerful concept which has been recently rediscovered—reinvented, if you will—and is now widely accepted in both the public and private sectors. Accrediting bodies have an ultimate social compact to protect and provide reassurance to the public as regards the quality of care being provided. For example:

- The mission of the Joint Commission is to improve the quality of care provided to the public through an accreditation process that promotes continuous improvement in organization performance. Quality improvement is the principal output of the accreditation process. (May/June, 1997)

- The National Committee for Quality Assurance (NCQA), the accrediting body for healthcare plans and managed care organizations, speaks of their mission in terms of enabling managed care accountability, driving quality improvement, and providing information on quality to the marketplace, specifically employers and consumers. (NCQA, 1998)

- CARF . . . The Rehabilitation Accreditation Commission cites as its mission, ". . . to serve as the preeminent standards-setting and accrediting body, promoting and advocating for the delivery of quality rehabilitation services." In addition, CARF's first stated purpose is, "To improve the quality of the services delivered to people with disabilities and others in need of rehabilitation." (1998)

The Accreditation Environment

The social, economic, and political dynamics that impact provider organizations in turn impact their accrediting bodies and their accreditation standards. That is, as the public policy agenda begins to address issues of the organization, delivery, financing, and quality of heath and rehabilitation services, the impact upon providers and their accrediting bodies is undeniable. In truth, standards are steadfast, but not static. The accreditation process and standards evolve over time to remain relevant to the state of the art of service delivery and to be responsive to—and even reflective of—the concerns, values, and concepts of each era or generation of human services. To cite only a few recent influences, note for example: the devolution of governmental authority to the states; the consumer movement including, specifically, disability rights; and the profound influence of the purchaser of health and rehabilitation services illustrated most dramatically in this era of managed care.

As emphasized, the accrediting bodies in a very real sense are derivatives of the field or industry that they are to monitor. While accreditors must stand independently, they cannot be aloof; for if they take a detached posture, they risk becoming seen as irrelevant. Indeed, if one were to systematically review the standards manuals of a human service accrediting body, one could clearly trace the cogent concepts and values of the time. In rehabilitation, for example, one could detect a movement from a near exclusive focus upon the professional provider to today's emphasis upon consumer participation and choice; from an emphasis upon organizational structure and process to a growing emphasis upon outcomes or performance; from a near "black box" mentality which held the details of the accreditation experience to be confidential to more interest in public information and open communications (note the President's recently proposed Consumer Bill of Rights as recommended by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1997).

Among the social, economic, and political forces impacting the providers, consumers, and purchasers of rehabilitation services and supports, one can identify:

- The Americans with Disabilities Act which holds all of our society accountable for access and opportunity.

- The Rehabilitation Amendments of 1992 which emphasize consumer choice, empowerment, and participation in community life.

- The various state and federal initiatives to reform and regulate health care delivery with special attention to managed care.

These public policy measures emphasize access to health care and information about health plans and providers. They also call for greater consumer participation in treatment decisions and often provide a mechanism for filing grievances and appeals.

- The impact of the consumer movement across society with special reference to the disability rights movement.

As consumers we now want to know more about the products we buy. In this day, who would purchase a new car, computer, or washing machine without first consulting Consumer Report? We also want to assess the universities and hospitals we turn to for education and health care (note the popularity of the ratings of such institutions in the recent issues of U.S. News and World Report). In rehabilitation the disability rights and independent living movements were in large measure a reflection of the social impetus for civil rights and consumer empowerment, choice, and participation.

The ubiquitous computer as a tangible manifestation of the Information Age.

While we may often feel overwhelmed with information, we have come to appreciate that we now have access to data and information which can enhance management, aid in analysis and assessment, and accelerate the decision-making process. The current focus upon outcomes and performance measurement is a direct by-product of this new found capability.

- The Total Quality Management (TQM) theology with its emphasis on data, continuous improvement, and consumer satisfaction.

With TQM principles highlighting the theme of maximizing quality while reducing costs, this movement has swept

throughout all sectors of the economy. In health care and rehabilitation, providers suddenly must discover a way to determine exactly what the person served needs, and the essential necessary service components, while at the same time maintaining or even enhancing the quality of care. In other words, achieve outcomes with tailored and essential processes. (Wilkerson, 1997)

- Marketplace dynamics—particularly the enhanced role of the purchaser of health care and rehabilitation services—as the overriding relevant economic theme of the 1990's.

As a society, we have reaffirmed our belief that product and service quality is best enhanced through competition and attention to customer satisfaction.

To draw upon an earlier theme, information, including information derived from accreditation and quality measurement, is absolutely essential in a competitive marketplace. Survival in such a marketplace depends in large measure upon an organization's ability to know its customers, its processes, its costs, and its outcomes. Over the last few years, both public and private purchasers of health and rehabilitation services have come to view and treat providers of such care as any other supplier of goods and services.

The spectacular growth of managed care in recent years is a direct testimony to the influence of a marketplace driven by the power of the purchasers in terms of: the individual to be served; the services to be provided; and the providers to be utilized. This new paradigm has understandably caused much anxiety, concern, and confusion among both providers and consumers of health and rehabilitation services. In their zeal to achieve greater control over the provision of services, purchasers have emphasized provider credentials. That is, many managed care organizations will include in their panel of providers only individuals and organizations which have been properly licensed, certified, and/or accredited. This is done in the spirit of exercising "due diligence" in protection of their members and serves as a low cost quality control mechanism. While the final decision as to selecting and utilizing a provider may be largely driven by costs and—to a growing degree—performance, the credentialing requirement essentially says to providers, "Unless you have the requisite credentials, we will not consider utilizing your services." Of course, in much the same way, public purchasers such as vocational rehabilitation, mental health, developmental disabilities, and workers compensation agencies adopted the same policy and practice years ago when they required individual certification and organizational accreditation before the public agency would refer clients to the provider.

By way of summary, it may be concluded that rehabilitation providers will be confronted with the challenge of implementing strategies to address the demands of the consumer-focused, outcomes-oriented, payer-driven environment of the 21st century. As delivery systems are restructured and as efficiencies and cost containment are pursued, it will be all the more essential to demonstrate that quality and accountability have not been compromised.

Accreditation as the "quality advocate" has an essential role to play in such an emerging environment.

A recent conference sponsored by The Institute on Disability and Managed Care of the United Cerebral Palsy Associations, Inc., entitled, "Managing the Winds of Change," (1998) perhaps best describes the environment confronting providers, consumers, purchasers, and accreditors. The conference brochure opens with the query:

> "Is your organization working to get in sync with the customer, get costs down and quality up in a dynamic environment of devolution, performance contracting, and consumer self determination?"

The Benefits of Accreditation

Accreditation makes diverse contributions to the field of rehabilitation practice and service delivery, to the consumers in search of qualified providers, and to those public and private purchasers of rehabilitation services.

In Terms of the Person Served

The standards developed and promulgated by an accreditation body have the potential to translate and operationalize values, principles, and enlightened public policy into daily practice touching literally millions of individuals with disabilities. For example, through conformance to standards, the following concepts and values become realities for persons served by rehabilitation organizations:

- The rehabilitation organization seeks, obtains, and uses input from persons served and other stakeholders.
- The rehabilitation organization engages in person-centered planning, design, and service delivery.
- The rehabilitation organization recognizes the rights of the person served and treats all persons served with dignity and respect.
- The rehabilitation organization makes a commitment to enhance the lives of the persons served as defined by the person served.
- The rehabilitation organization appreciates the value of diversity and is culturally competent in serving its clientele.
- The person served is an active participant in planning, selecting, and evaluating the services provided by the rehabilitation organization.
- The rehabilitation organization demonstrates a clear focus on its customers, its customers' expectations, and the results of services provided in terms of the achievement of goals and customer satisfaction.
- The rehabilitation organization meets the requirements of the Americans with Disabilities Act.

- The rehabilitation organization acts as an advocate for access to care for people with disabilities and for the removal of architectural, attitudinal, communication, employment, and other barriers to people with disabilities.

Lastly, accreditation offers confidence to consumers that an independent review process is in place specifically focused on improving the quality of the rehabilitation services they receive.

In Terms of the Management of Rehabilitation Organizations

Most accrediting bodies have standards that address the organization and management of provider organizations. These standards, for many rehabilitation administrators, provide their first exposure to management principles—a kind of "Management 101" for individuals who have been trained as counselors, psychologists, social workers, and therapists. Organization and management standards commonly address:

- Governance.
- Strategic planning.
- Financial management.
- Information Systems.
- Outcomes Measurement and Management.
- Human Resources.
- Health and Safety.

Such standards provide an accepted blueprint for efficient and effective operations, a quality improvement strategy, and a management tool to continually evaluate and improve services and programs. It should also be noted that consumers and family members frequently have concerns regarding the survivability of the provider organization. Parents of a young person with a disability being served by a community rehabilitation organization want assurance that the organization is well run, solvent, and will be there to provide services and supports over many years.

In Terms of Recognition

Accreditation identifies to consumers, providers, purchasers, public officials, and the general public those organizations that meet recognized standards. In terms of the marketplace dynamics cited earlier, such recognition has become increasingly essential. As Cherilyn Murer, JD, has written, "Purchasers are telling individual provider organizations that performance evaluation begins with accreditation. Accreditation is a ticket to play." (1997) Further, and as noted above, in consideration of their due diligence responsibilities, purchasers are not likely to assume the unnecessary risk of utilizing providers who do not achieve accreditation, the first level of quality assurance.

Purchasers also recognize the public relations value of adopting a policy that declares, "We only purchase services for our employees, subscribers, or clients from organizations that are nationally accredited."

Recognition takes many forms. For example, Standard and Poors (S & P) has begun to rate human service providers. In their April 1994 report, S & P states:

> "Accreditation, where appropriate, by national bodies such as the Commission on the Accreditation of Rehabilitation Facilities (CARF) serve as indicators of compliance with professional standards [sic]."

They advised that such an indicator of provider professionalism, along with funding history and market share, impact the financial ratings of quasi-governmental providers and free-standing nonprofit community agencies.

In a report to the author, the Kresge Foundation of Troy, Michigan, reported on a survey they had conducted dealing with grant-making to human service organizations. Respondents to the survey had advised that grants should only be made to agencies that had achieved national accreditation, ". . . because it is an indicator that the agency is concerned with quality and it improves their credibility and reputation in the community." (1994)

In Terms of the Government

As noted earlier, the public sector—including the federal government, states, counties, and municipalities—often establishes inter-relationships with independent accrediting bodies, sharing responsibilities—and accountability—for human service quality assurance. The term "deemed status" is used to mean that, via national accreditation, the provider organization is "deemed" to have met the public agencies' regulatory requirements. Such arrangements are attractive to governments for at least three reasons.

1. They demonstrate public-private partnerships, sharing of responsibilities and authority, and a pluralistic approach to monitoring and oversight.

2. The use of an external accrediting body with its established criteria, standards, and independent reviewers relieves the government of charges that the state funding agency is biased or politically motivated in the award of contracts or the referal of clients. This goes directly to the issue of conflict of interest.

3. And finally, the use of an external accrediting body relieves the public agency of some of the costs of employing its own reviewers. It is not uncommon for a large state which does not utilize accreditation to employ hundreds of state employees to engage in periodic visits to provider organizations.

Accreditation . . .Some Basic Principles

To provide assurance that services and supports are being effectively monitored and evaluated and are being held to high performance expectations, national accreditation bodies share many common principles and approaches. These principles have evolved over the years and reflect the purposes, values, and vision of the accreditation organization. The typical national accreditation body engages in:

- The development and maintenance of state-of-the-art standards that provider organizations can use to assess and improve the quality of their programs. The standards are often performance-based and consumer-focused and address key processes that providers must utilize to produce good outcomes.

- The inclusion of various stakeholders—including consumers, providers, and purchasers—in the governance of the accreditation body and in the development of standards.

- The provision of independent, impartial, experienced, and qualified peer reviewers as surveyors.

- The application of standards in periodic on-site visits where services are actually delivered.

- The provision of suggestions and consultations during the site survey along with the application of standards and evaluation of the organization's policies, processes, and performance.

- The provision of a survey report following the site visit with observations, commendations, suggestions, and recommendations to improve conformance to standards where the organization has demonstrated deficiencies.

- The requirement that the provider organization prepare and submit a quality improvement plan to address program deficiencies as identified in the survey report.

Trends in Accreditation

Accreditation standards and processes should be faithful to legislation and public policies, informed by state-of-the-art professional practices, and driven by the quality and accountability imperative. The quality imperative is also expressed in terms of emphasizing continuous quality improvement in management and service delivery and in the recognized need to enhance performance measurement and management.

To fulfill their accountability mission, accreditors must also be growing, changing, and responsive to their environments. Accrediting bodies are themselves engaged in a competitive environment, their performance is scrutinized, and if they fail to deliver quality services or keep current with developments, they will lose customers and market share. To stay current, competitive, and responsive, there is a need to focus on the basic validity and reliability of the accreditation process.

There are several trends which can be identified in terms of the evolution of accreditation practices in response to new developments and expectation. Among these trends, one may cite the following:

- Outcomes Measurement and Management

As noted earlier, while standards typically address organizational structure and management and service delivery processes, there is growing emphasis upon the outcomes—results for persons served—and on the use of outcomes information in managing programs and enhancing service delivery.

Rehabilitation administrators, clinicians, and researchers have had a long-standing interest in results, benefits, and the impact of services provided on persons with disabilities. For over twenty years CARF has required that providers evaluate their programs in terms of effectiveness, efficiencies, and customer/consumer satisfaction. JCAHO has introduced the ORYX system which requires health care providers to utilize approved outcomes measurement systems, while NCQA has created the HEDIS system requiring health care plans to report specific data on approximately thirty health care interventions (i.e., childhood immunization, breast cancer screening, follow up after hospitalization for mental illness, member satisfaction, etc.).

- Performance Indicators

Dennis O'Leary, M.D., President of JCAHO, states, "The use of performance indicators will first of all change the focus of attention from compliance to standards to actual results." (September/October, 1996).

In this age when public and private purchasers are shifting from "buying programs" to "buying results," it is imperative that performance-oriented indicator systems be developed. Sean Sullivan (1997), of the National Business Coalition on Health, advises that providers and purchasers need to agree on indicators that are credibly reliable. He emphasizes that purchasers are moving from a "buy and measure" approach to one of "measure and buy." Purchasers are clearly looking for those providers who are willing to both submit to measurement and communicate their results.

Performance indicators address the essential question, "What does a stakeholder want to know about a program's performance in order to assess its quality and to choose among providers?" To be reliable and valid, however, there must be agreement among stakeholders as to the essential indicators to be measured. In order to achieve legitimate "apples-to-apples" comparisons, several technical concerns must be addressed including measurement approaches, risk adjustment, and uniformity of reports.

Rehabilitation Continuum Report (July, 1998) asked a group of experts in medical rehabilitation to name the most important indicators that should be tracked. They reported the following:

- Discharge rate to the community

- Productivity of the individuals served (work, school, family role)

- Durability of outcome

- Improvement in functional independence and performance of typical activities of daily living

- Length of stay
- Value of outcomes (cost of care versus the outcomes achieved)

- Public Information

Until recently, the results of the accreditation site visit and survey report were considered to be confidential information between the provider organization and the accreditor. Typically the accreditation body would only report the provider organization's accreditation status and the duration of the accreditation award.

In response to the demands of the general public, consumers, and purchasers, most accreditors have begun to alter their information dissemination policies. Some even post the survey report or a summary of the report and scores on the Internet. The press for more information on provider performance addresses the trends toward consumer empowerment and choice which are vital considerations in rehabilitation and among the general public. Cherilyn Murer states, "The baby boomers are having a major impact on accrediting bodies with their demand for disclosure." (1997)

According to a report in The Journal of the American Medical Association (1997), reports to consumers that rate the quality of care delivered by hospitals and other health care providers not only help patients and families make informed decisions, but also spur improvement in the care provided. The study, which surveyed changes in services offered to obstetric patients in 82 Missouri hospitals, found that 50% of hospitals had either improved their practices or planned to do so within one year of release of a report to consumers.

Daniel R. Long, M.D., Associate Professor of Medicine at the University of Missouri, stated:

> "But not only do we find that consumers read these reports, but providers—physicians and hospitals—read these reports. In our study, we found that providers took the reports seriously, looked at how they compared with one another, and they made necessary changes in the nature and type and quality of services they provide to pregnant women and infants."

Conclusion

Accreditation bodies want to provide a value-added service—one that provides a quality guide for provider organizations, a signal of quality to consumers and purchasers, and assurance to the public that accredited health and rehabilitation organizations are accountable and should be supported. Such added value applies equally to the accountability of the field to persons served and the accountability of the accrediting body to the public at large.

Accreditation should not be viewed as an end in itself, but should serve as an opportunity to reinvigorate, to redesign, and to engage in system change while enhancing the organization's development and capacity to accommodate and succeed in its ever-changing and challenging environment. It is no longer a cliché to state that we are in the vortex of substantial, pervasive change—change in the relationship between government and the individual; change between the federal government and the states; change between the public and private sectors; and change between providers of rehabilitation services and the consumers of those services.

In the face of such change and dislocation, national accreditation can serve as a common ground for provider organizations, consumers, families, purchasers, and the community. National accreditation can, in fact, provide partnerships, associations, forums for common interests, and a vestige of stability and standardization in the ever changing rehabilitation environment. Seeking that critical balance between principled stability on the one hand and flexible, constructive response to the very real revolution in the organization, delivery, and financing of health and rehabilitation services on the other hand will no doubt continue to challenge the accreditors.

Notes

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Accreditation, when based on a firm substrate of strong outcome research and program evaluation yielding clear criteria will remain a potent tool facilitating quality control in a subset of rehabilitation organizations. That subset corresponds to what Dr. Galvin terms "accountable" rehabilitation organizations. The benefits to these organizations are articulately presented, not as an end in itself, but as a means to achieve accountability. Such facilities, for example those supported by government funding, are clearly motivated to adhere to the specifications of their contract. To the extent that a contingency relationship exists between the characteristics of interventions or outcome measures and continued funding or awarding of grants, knowledgeable consumers will be empowered to guide the process.

This is an essential ingredient in many sectors within rehabilitation. We cannot lose sight of the need, not only for ongoing outcome and program evaluation research with which to guide future practices, but also the need to continue effective dissemination of this information.

Some consumers, given their limited knowledge of rehabilitation and their particular circumstances, are not yet able to accurately gauge needed services or to discern the appropriate calibre of rehabilitation practices necessary for their applications. Many consumers of forensic rehabilitation services, for example, may have difficulty distinguishing among practitioners, given the various groups claiming to certify, license and train practitioners. Other consumers focus on the attainment of salient, yet short-term goals, rather than focusing on the long-term best interests of the individual with a disability. For the more formidable large volume purchasers of rehabilitation services, accreditation is indeed a friendly and vigilant overseer of standards, as well as one of the best predictors of quality controlled service provision.

Dr. Galvin quotes Sean Sullivan's definition of accountability as "being responsible for those things over which one has l..." (emphasis added). Purchasers of vocational evaluation, rehabilitation planning, and potential service provision for injured workers involved in litigation or administrative procedures often know little more than the man on the street regarding quality services. Often, other criteria are applied. Their selection of service provider may not only be made to the detriment of the vocational rehabilitation of the injured worker, but may also be imposed upon jurors and the administrative or judicial system in general.

The consumer within the forensic arena is often confronted with mixed messages. Further, the consumer often is confounded by multiple certifications which differ in significance for the purposes retained. Some of these certifying groups fail to enforce ethical guidelines and standards among their members, e.g. they are not appropriately held accountable for their professional behavior.

Craig L. Feldbaum

As a result of the 1992 Amendments to the Rehabilitation Act, the issue of informed client choice was codified and generally accepted to be critical to the successful outcome of the vocational rehabilitation plan. In the V.R. system, we struggled with ways to operationalize choice so that the information that was provided by the Counselor would be, as the Weather Channel slogan goes, "accurate and dependable". And, just like the weather report, our internal quest for rating programs, schools and service delivery systems sometimes left us unprepared with what could happen when the wind shifted.

After we tried a series of anecdotal surveys of training programs and schools that yielded successful outcomes (placements) and customer satisfaction studies for other vendors dealing in equipment or restorative services, we realized the additional need to rely on a more objective approach from an outside resource. We have had great success with CARF's approval of rehabilitation facilities and we've expanded this accreditation to include other community rehabilitation programs. While we haven't been as definite with trade or business schools, there is hope that these programs begin to self police as the market for their services grows to match the emerging need.

Dr. Galvin is correct when he reminds the reader that more than a few of us have been know to consult Consumer Reports (or the Internet) to find the safest car, the most reliable refrigerator or the best stereo speakers. We are a nation of score keepers, from listing the top ten universities to evaluating the best cup of coffee; we want to know what's best. And, why shouldn't we extend that to the goods and services that are purchased and consumed through public funds?

The Rehabilitation Act's regulations governing the Comprehensive System of Personnel Development (CSPD) defining and demanding qualified rehabilitation personnel and the many states adopting rehabilitation counselor licensure laws make this issue timely and critical to the future of the V.R. service delivery system. It is necessary for us to seek out the quality service at every level and to shun any hint of the "good enough".

Brian Fitzgibbons

Donald Galvin makes the assertion that "accreditation can be a powerful tool for achieving quality in the management of accountable rehabilitation organizations, including quality in the services and supports provided and in the outcomes achieved." He maintains systems of "quality assurance such as accreditation bodies must also be accountable." He sees the accrediting body acting the public's interest to set standards of practice in a field, to evaluate conformance to those standards by organizations in the field, and to communicate that information to interested parties.

To the extent that the accrediting body acts in this capacity, it is vital that affected "parties" have representation in the decision making process, planning, and implementation of such standards especially as they relate to service delivery, training and program development. It is of particular importance that the representatives be involved in each phase to ensure that prac-

tice standards: (1) fit the jurisdiction for which standards are being advanced, and (2) are culturally competent. In addition, cultural competence training should be a major component of the pre-service training requirements in educational institutions and in-service training requirements in vocational rehabilitation agencies.

Kimberly Turner

Accreditation and outcome/accountability measurements are intertwined. In our efforts to produce and report outcomes, the process of obtaining those outcomes must also be considered.

1. Recommendations/Implications that would enhance service delivery:

- More consumer involvement in the development of accreditation standards.

- Consumer involvement, as surveyors, in the actual survey process.

- Accreditation is protective of consumer services. If required, accreditation prevents less than quality providers who have no long-term commitment to consumers.

- Marketing the value of accreditation to consumers, families and advocacy groups will enhance the quality of the programs and services delivered.

- The quality of service delivery will improve if funders and referral sources require community organizations to be accredited.

- Multiple accrediting bodies should be encouraged. Competition between accrediting bodies is positive and promotes quality.

- Accreditation must be seen by providers as a cost of doing business.

2. Recommendations for Program Development:

- The industry must determine appropriate and valuable performance indicators.

- The process that occurs, through accreditation, of sharing best practices should be encouraged and expanded.

- Organizations that participate in an accreditation process that uses outcome measurements are forced to look at programs and services critically and to clearly define them in terms of the intended outcome.

- Accreditation can be a powerful tool in the marketing of services.

3. Recommendations/Implications for education and training:

- Unexpected peer reviews at organizations to assist them in the provision of quality programs on an ongoing basis (not just for the few days of the accreditation survey process).

- Establishment of a numerical system to rate program quality. over time, will allow truly excellent programs to be identified and replicated. This will also allow a relationship between best practices and positive outcomes to be identified.

- Research findings on the value of accreditation as it relates to positive outcomes should be disseminated to funders, consumers and advocacy groups to promote the value of the accreditation process.

4. Recommendations implications for needed research

- Comparative studies to determine if accredited programs lead to better consumer outcomes?

- Conduct interviews of agency staff who have just undergone an accreditation survey asking, "What did you do to prepare for accreditation and what impact did that preparation have on your services." If the majority can list positive benefits to accreditation preparation, this information can be used to positively market accredited services.

- Research conducted on the team building and quality management improvements occurring in organizations that go through an accreditation process.

- The results of the research findings must be widely disseminated to funders, consumers and advocacy groups.

5. Recommendations/Implications for policy (Legislation – Federal, State, Local):

- A recognition that states are making decisions now, not the federal government as regards program standards and quality.

- State agencies should be encouraged to adopt policies requiring the use of accredited providers in their purchase of services

- Consumers should advocate for and require that their services be provided by accredited organizations.

4. Other Observations:

- Welfare to work thinking (numbers of people off the system) is spilling over to other public programs. What are the implications for service quality?

- The previous findings of the GAO report on rehabilitation programs is still being used to negatively affect the status of Rehabilitation services.

- There is currently no federal leadership on public policy issues affecting the independence and employment of persons with disabilities.

- There is sentiment at the federal level to eliminate all "civil rights" type programs. Rehabilitation and the ADA are seen in that light. - **Beth Robertson**

Vocational Rehabilitation and Cultural Competence: Considering Accountability

Mr. James Mason

As America enters the twenty first century it will be much more culturally, racially, and linguistically diverse (Ponterotto & Casas, 1991; Lum, 1992; Sue & Sue, 1990). One consequence will be that health and human services agencies will be called upon to provide services to a much different set of consumers and communities. Vocational Rehabilitation as a service discipline will encounter many cultural, racial, and linguistic issues in serving these projected diverse populations. To meet the needs of these projected culturally diverse groups, vocational rehabilitation has begun to wrestle with the concept of culture as an issue in providing services (Kunce & Cope, 1969; Steinberg, 1977; Rivera & Cespedes, 1983).

This renewed concern for cultural diversity comes at an important juncture. The tax paying public is demanding greater fiscal accountability with regard to domestic programs. Consumers and advocates are seeking greater accountability in access to, quality of, and influence over rehabilitation services (Turnbull & Turnbull, 1990; Hosack & Malkmus, 1992. Private and public funding streams are also starting to exert pressure for accountability in the provision of services for culturally diverse populations (Cross, Bazron, Dennis, & Isaacs, 1989).

Thus, vocational rehabilitation is at a very important juncture. As a field it can separate the concerns for accountability from those of cultural competence and treat them as discreet concerns. Or instead, vocational rehabilitation may recognize this as an opportune time to integrate the concepts of cultural competence and accountability. Their are pressures from various people, communities, and organizations concerned with greater accountability in service provision, obviating the challenge of 21st century to integrate these two important concepts.

There has been considerable work done with respect to cultural competence over the past fifteen years (Green, 1982; Ho, 1987; Ponterotto & Casas, 1991; Pinderhughes, 1989; Sue & Sue, 1990; Lum, 1998). Further, computer and other information technology is becoming increasingly accessible and user-friendly, making the possibility of collecting and analyzing various forms of client demographic, outcome, and satisfaction data much more convenient. Vocational rehabilitation can shy from the challenge or take advantage of the opportunities to enhance service delivery to culturally diverse populations.

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Contextual Issues and Cultural Competence in Vocational Rehabilitation

In designing culturally competent systems of care, many contextual issues need to be considered. One is that cultural competence as a concept is still in its development stages, much is being learned everyday. In spite of the impending diversity in American society, many have yet to see the role that culture plays in the helping process. Some may see the concern for diversity as an event or fad as opposed to a systemic shift in how services are delivered (Isaacs, 1998). If cultural competence is to be implemented professionals must be initially accountable for explaining to a variety of constituencies why this road was taken.

The possibility that many vocational rehabilitation professionals are not prepared to address this argument effectively, diminishes the prospect of creating culturally competent systems of care for all clients. Metaphorically speaking, in this war of attrition vocational rehabilitation professionals will need ample ammunition (e.g., rationale, theory, data) to counter ideas that trivialize or minimize the importance of cultural and linguistic differences in the helping process.

Another barrier to integrating these concepts concerns the fact that cultural competence requires doing some homework. Because it is a strengths model, it loses viability when professionals do not know the diverse groups in terms of culturally-based strengths, resources, and assets. If professionals are only aware of the diverse groups in terms of their real and imagined problems and deficits, considering cultural differences may yield negative or unwanted results (Cochran, 1988; Cross, et al., 1989; Pinderhughes, 1989; Lum, 1998; Sue & Sue, 1990). The educa-

tion of many professionals lacked a cultural dimension, therefore, agencies may need to be accountable for how they orient new, or re-orient more experienced staff to this concept. American culture is chocked full of myths, negative attributions and stereotypes (new and old), and general fears regarding many diverse populations. Supplanting this skewed knowledge base with a more benign view of cultures and cultural strengths is an important preliminary step to consider as the road to cultural competence does indeed go through cultural awareness territory (Green, 1982; Lum, 1998). Professional and graduate schools are racing to develop cross cultural curriculum (Sanchez & Demmler, 1990). Even so, local, regional, and national service bureaucracies may need to convene relevant and informed cultural competence training activities.

Many human service professionals have not been formally trained to consider the cultural beliefs and practices of culturally diverse groups (Pedersen, 1988). This lack of cultural training while problematic, is exacerbated because few culturally diverse professionals, consumers, or advocates are represented in planning, policy- and decision-making meetings. Again, vocational rehabilitation must also be accountable for improving strategies which effectively involve diverse communities in the design of services and service delivery approaches. Similarly, representation in this vein can contribute to the recruitment, development, and training of a diverse work force prepared to provide culturally competent services.

A major concern is the recent backlash felt in America regarding the changes to make this a more equitable society. Many have clamored that attempts to improve services for diverse groups will come at the expense of the dominant culture. As America diversifies, many see such efforts as this as a potential threat to the "American way" or their own security. Agencies have not been accountable in explaining to the general public how acknowledging and preparing for diversity will have benefits for all Americans. Sue (1992) asserts that services that take culture into account do not necessarily imply preferential treatment.

The good news concerns the fact that as field, vocational rehabilitation has many professionals and professional organizations seeking methods of improving services. Another positive, is that many disciplines are beginning to embrace cultural competence as a value (Ponterotto & Casas, 1991). Cultural competence research is being conducted to identify best practices (Isaacs & Benjamin, 1991). While the field is not as diverse as perhaps the country, years of affirmative employment strategies has interjected some diversity into the equation. The future requires the development of a culturally diverse workforce to achieve employment equity and enhance the cultural competence of vocational rehabilitation services.

There are diverse contextual issues, some regional or even local in origin. Adding fuel to this equation, contextual issues are not static in nature. Cultural groups and their circumstances constantly change. The field must be proactive in asserting why this concern for cultural competence is in the best interest of the country, its economy, and all of its people. Again, much homework is needed, however, positive forces are in place and the infrastructure appears amenable to change.

This discussion will not be an exhaustive review of theories regarding accountability. Such theories are constantly emerging and evolving, and are very numerous. More time will be spent in examining opportunities to integrate these concepts. Vocational rehabilitation will need to dialogue in order to identify or develop and subsequently evaluate accountability measures. This developmental stage must seek to insert the concern for cultural competence at all stages of this process.

Because cultural competence is an emerging concept in a variety of health and human service fields, vocational rehabilitation can build on the experiences of others. But the field must also be prepared to adapt existing or develop new materials that are specific to vocational rehabilitation, to culturally-specific populations, and for an increasingly multicultural society.

Professionals and organizations considering the development of culturally competent systems of care will need to be accountable for understanding relevant contextual issues and there implications upon the utilization of the cultural competence model.

Professional Accountability in Advocating for Cultural Competence

Cultural competence is being a relatively new concept and therefore is not fully comprehended by many in the field. Professionals need to distinguish this concept from the earlier models of cultural awareness and sensitivity (Pedersen and Lefly, 1986; Green, 1982; Solomon, 1976). These earlier models can be viewed as cognitive based (Pedersen, 1988). Cultural competence goes one step further by including a behavioral dimension (Cross, et al, 1988; Lum, 1992, 1998). Some have even argued that there is a conative dimension that consider the emotions and feelings of the professional and the consumer.

Cultural competence has taken a more prominent role recently because many communities are starting to experience the projected browning of America. Rural, suburban, and urban communities are starting to witness significant changes in populations; and projected populations. While many of the cultures and beliefs of the historic ethnic groups in America were never fully understood, newer and additional challenges will come in the form of newer cultures emerging in American society; particularly those emanating from non-modern, rural, indigenous societies.

Many professionals and professional organizations are aware of the shifts that are occurring. However, from an accountability standpoint modern professionals, will need mechanisms for staying abreast of population changes and the implications thereof. That means that in addition to quantifying the changes, systems will need to understand the potential implications. For example, early in the 21st century African Americans who have comprised the largest non-European ethnic group in America for sometime, will slip to number two and subsequently number three. Systems can create serious problems by forsaking traditional groups for newer ones.

Another example manifest itself in the projected growth of the Hispanic or Latino-American population or other communities that use a different language. However, this acknowledgment

reveals a systemic problem. While some wonder why the attention is focused on culture, there has been less suspicion with respect to language. Many communities and providers are now both clamoring for workers who can work across differences in language. This concern for bilingual staff must be considered in the context of addressing cultural differences. (Lum, 1998). Being bilingual does not assure sensitivity to cultural differences. There has been considerable work done in the importance of linguistics in health services (Sue & Sue, 1990; Tirardo, 1996), but this issue should run parallel to but not overshadow the concern for cultural competence.

One important impetus for the consideration of cultural competence is the demographic projections that are being forecast for America. Professionals and organizations need to stay abreast of these changes. In addition to being aware of the numbers, accountable systems will also need to understand the cultural strengths (Sue & Sue, 1990; Lum, 1992), normative behaviors (Neighbors, 1986; Ho, 1987; Pinderhughes, 1989) and ecological stressors (Isaacs, 1986; Gibbs & Huang, 1989; Lum, 1998) of their service populations, historically and in contemporary society.

Surely agencies and professionals need to be aware of the numbers (demographic changes), but the circumstances under which these groups live and how they cope are equally important. Knowing the ecological conditions would aid in the design of services and programs, and might involve understanding diverse communities in terms of such issues as life expectancy, special education systems, housing patterns, crime rates, infant and adult disability rates, and national origins and languages. Fortunately, much of this information has been collected and compiled, and is readily available in both electronic and printed formats. Agencies and programs cannot begin to empower individuals, let alone communities, if they are unaware as to how these entities are at-risk in American society. Local governments, colleges, chambers of commerce, and census bureaus often make resources available.

Most of the forecasts about population shifts concern national shifts or impacts on major cities. However, these projected shifts are extensive enough that diverse populations are likely to emerge in all segments of American society. Programs and staff in all areas of the country should develop mechanisms to assure they remain sensitive to population changes and the subsequent implications for service modifications.

To reiterate, accountable systems that are adopting cultural competence must be able to explain why. Historically, service provision typically did not consider the culture of the consumer; and there has been a history of dubious practices against certain populations (Edson, 1989). This history, particularly when unacknowledged can create an obstacle to establishing culturally competent systems of care. Most services and delivery systems were designed to reflect dominant culture values, behaviors, and norms. (Green, 1982; Cross, et al., 1989; Sue & Sue, 1990; Lum, 1992,1998).

Taking this another step further, often programs were antagonistic to diverse cultures spending considerable time and effort to supplant diverse cultural behaviors with those of the mainstream (Cross, et al., 1989). Frequently this practice of instilling mainstream norms did not always produce positive outcomes. Many diverse groups are aware of such historical antecedents and contemporary inequities that occur in various disciplines ranging from the Tuskegee experiment for African Americans, eugenics for people with disabilities (Edson, 1989) and the poor, and the boarding school movement for Native Americans (Cross, et al., 1989). New ethnic groups coming to the United States bring with them varying fears and experiences associated with public or governmental bureaucracies. They also bring a history of their own informal help mechanisms and present issues that often require greater knowledge than ever before.

Undoubtedly, vocational rehabilitation professionals are not responsible for the problems created long ago, but they may be responsible for their response to them. Therefore, public systems must accept accountability for possessing greater knowledge, if they are to remain responsive to funding streams and consumers. To effectively engage ethnic communities and clients may require changes on both sides (i.e., provider and consumer), especially if both sides only know of each other in terms of perceived deficits.

An unfortunate aspect of this issue, regards the fact that few professionals were trained to deal with culture or race as a variable in the helping process (Ponterotto & Casas, 1991). When vocational rehabilitation workers were trained, many were by default, instructed in mainstream values. Many professionals understand the general issues faced by people with disabilities in vocational rehabilitation systems, but this awareness wanes when considering it in the context of African-, Asian, Latino, or Native American culture. Understandably, people are quick to perceive or anticipate pathology in a culturally diverse consumers family, community, or culture as the problem. Until this thinking is corrected, the field may be hard pressed to utilize cultural and community based strengths in delivering respectful and relevant services.

One must also consider the impact of social learning and informal education. In this perspective family values, community folklore, fables and myths, stories, books, movies and other cultural manifestations have not prepared us for diversity; if anything just the opposite has occurred. Coupled with the segregation of American society (de facto or de jure) many cultural and racial myths and fears have become widespread. Many Americans , not just the bigots, have been influenced by cultural and racial stereotypes, deficit based curriculum, and otherwise misleading theories. If agencies and professional organizations do not provide strengths based training as an alternative, creating culturally competent systems of care may again be difficult. Accountability measures need to be developed regarding the training necessary to serve a multicultural community.

Vocational rehabilitation organizations, systems, even agencies can convene seminars, identify cross cultural training resources, or otherwise support cultural learning opportunities for its staff, board, volunteers, consultants, even consumers. Providing training that does not prepare staff to address problems encountered when engaging the community will not facilitate accountability. It may not be possible to have a culturally compe-

tent work force and services if accountability in cultural competence is ignored.

Having cross cultural knowledge is an important aspect of cultural competence (Cross, et al., 1989; Lum, 1998). Ultimately, local, regional, and national vocational rehabilitation systems and bureaucracies need to develop accountability measures that promote cross cultural knowledge vis-a-vis staff training and development. Training and development must prepare staff to: be aware of the diverse cultural groups in a service area, comprehend and utilize culturally competent approaches, understand why cultural competence is important for all customers, and work in concert with the clients support system.

For managers and administrators, accountability will also be important. Agencies and systems will need to assure that management staff will be culturally knowledgeable about: developing and managing a diverse work force (Woody, 1992; Fernandez, 1991); mediating cross cultural conflicts; and engaging formal and informal supports needed to create individualized systems of care (Pinderhughes, 1989; Lum, 1992) and involving diverse community leadership in the design and delivery of services (Cross, et al., 1989).

Cultural Competence and Behavior

In the 21st century vocational rehabilitation systems and bureaucracies will need staff who are knowledgeable and aware of the existing and emerging culturally diverse populations. competence and diverse populations. Because cultural competence involves behavior vocational rehabilitation programs will also need to be accountable for how this concept is actually manifested. Many people were trained in some cultural aspect or another. Yet, these training activities did not always involve an action component. To give cultural competence life, vocational rehabilitation programs will need to convert cultural knowledge into behavior. In the 21st century the marketplace will be comprised of a more culturally, racially, and linguistically diverse consumer population. Programs will need to be able to explain how cultural competence is reflected in service delivery. Demands for cultural competence may also come from funding streams. Consumers are also "chomping at the bit" on this issue, and will manifest this demand by seeking providers who have workers that reflect their race, culture, national origin, or language.

Developing a Value Base for Culturally Competent Systems of Care

Some impetus for change will come from vocational rehabilitation agency managers and administrators. Their efficacy will be their ability to effectively advocate for changes to enhance services to culturally diverse populations. The cultural competence model developed by Georgetown University Child Development Center (Cross, et al., 1989) suggests that agencies must have the wherewithal to change the way they provide or enhance services to diverse populations. Programs can benefit from adopting a value base for cultural competence. The Child and Adolescent Service System Program (CASSP) cultural competence model lists agency values conducive to creating an culturally competent system of care, they include:

1. Respecting the unique, culturally defined needs of diverse client populations.
2. Acknowledging culture as an prevailing factor in shaping client behaviors and values, as well as human and health service organizations and institutions.
3. Understanding when values of diverse cultural groups are in conflict with mainstream or organizational values.
4. Believing that diversity within cultures is as important as diversity between cultures.
5. Acknowledging and accepting that cultural differences exist and have an impact on how services are delivered and received.
6. Viewing natural systems (family, community, places of worship, natural healers, etc.) As primary mechanisms of support.
7. Recognizing that the concepts of individual, family, and community can differ from culture to culture, and even within cultural subgroups.
8. Starting with the family as defined by each culture, as the primary and preferred point of intervention.
9. Respecting the family as indispensable to understanding the individual.
10. Respecting cultural preferences which value process rather than product, and harmony or balance within ones life rather than achievement.
11. Recognizing that people of color have to be at least bicultural, which in turn creates its own set of behavioral issues.
12. Advocating for culturally competent services.

These beliefs listed above begin to infuse systems with values and perspectives conducive to becoming more culturally competent. Agency personnel must become familiar with these values in order to operationalize cultural competence. Without a solid foundation as to how and why, the concern for accountability suffers greatly. Additionally, without proper grounding in these issues, agency personnel may trivialize the concern for cultural competence. Often upper level staff are exposed to understanding why changes must occur, however, if this does not permeate all levels of the agency accountability suffers and the focus on diversity can be diminished.

Diverse Target Populations and Cultural Competence

Professionals must have knowledge and skills reflecting the groups in their respective catchment areas. Without specificity, cultural competence and subsequently accountability are hard to promulgate. Earlier strategies for dealing with diversity focused generally on minorities. There was not enough attention as to how various minority populations sought help (Neighbors & Taylor, 1985), defined problems and solutions (Sue & Sue, 1990), and the environmental issues and stressors they faced different from mainstream populations (Isaacs, 1986).

Program managers need to be more exacting in describing the diverse populations and more asserting that everyone has a culture (Cross, et al., 1989). They must also be knowledgeable in considering various target populations in terms of differences in utilization rates. In many areas for example, cultural groups of color (and subsets) were often under- and mis-served by mainstream organizations (Zane, 1986; Green, 1982, Sue & Sue, 1990; Lum,

1998). Time must be spent identifying which cultural groups are under served.

The model must remain sensitive to between and within group differences (Ponterotto & Casas, 1991). and avoid developing new stereotypes for professionals rushing to improve agency practice and administration. In addition to benefiting the four groups of color (i.e., African-Americans, Asian-Americans and Pacific Islanders, Latino- or Hispanic Americans, and Native Americans) culturally competent systems of care have to be responsive to all people. Cultural competence can target groups of color as culturally diverse, but must also be responsive to the unique service needs of non-ethnic cultural groups (Atkinson and Hackett, 1988). Non-ethnic cultural groups (e.g., seniors, people with disabilities, women, the poor, gays and lesbians, youth, homeless populations) are often vulnerable in different ways than groups of color, and different still from immigrants and refugees. The term or concept of minority when used indiscriminately blurs the cultural differences and exacerbates service delivery. When people of color, non-ethnic cultural groups, and immigrants and refugees are thrown into the multicultural stew, efforts to improve services can be confused.

Again, it is important to examine utilization rates, outcomes, and satisfaction rates with services (family and customer), and evaluate client functioning by cultural group. Typically, outcomes for groups of color have suffered in such comparisons. If a system is to be accountable it must know which groups are not getting served or which ones do not benefit fully from the agencys efforts. Simply stating that an agency serves minority or diverse populations, without specificity as to the group issues in the context of the agencys mission may not pass muster with respect to cultural competence.

Given the history of health and human services in America, focusing on groups of color was a natural and easy place to start. Many cross cultural theories have emerged, service disparities in service outcomes have been documented, and the cultural behaviors of the groups of color although widely studied, have often been misunderstood. This is not to say that cultural competence must focus on groups of color, non-ethnic cultural groups, or even immigrants and refugees. But, some groundwork must be done to determine which groups (and subgroups therein) will be the targets of agency interventions.

Being culturally knowledgeable facilitates vocational rehabilitation program managers and administrators ability to develop skills necessary to come up with the cultural competence strategies that will improve service delivery. These strategies must build upon a knowledge base of how ethnocultural groups of color in America utilize health and human service delivery systems. This knowledge base must address how the values and practices of mainstream agencies and institutions conflict with those of the diverse cultural groups (Green, 1982; Zane, 1986; Pinderhughes, 1989; Sue & Sue, 1990; Lum, 1998). Additional knowledge is needed as to how to further involve the many ethnocultural groups of color who have been under represented in positions of power and influence.

For many managers it may be helpful to convene sessions whereby cultural key informants can describe their culture, explain how it influences service utilization and customer satisfaction, outline ecological stressors and barriers that inhibit service delivery, and the types of practical interventions and service delivery approaches that may yield the biggest benefit (Isaacs, 1986).

Cultural Model Adaptions for Vocational Rehabilitation

Cultural competence has been considered by many disciplines over the past ten years, as mentioned earlier, the various models all emphasize behavioral changes. Definitions may differ slightly according to the model, however, common themes emphasize cultural awareness, knowledge, and skill (Ponterotto & Casas, 1991). The CASSP model stresses attitudes, practices, policies, and structures; a developmental continuum; and five key principles (Cross, et al., 1989). Most models recognize the importance of self-awareness and ongoing education, paying attention to within- and between-group differences, and that becoming culturally competent is a developmental process (Green, 1982; Ho, 1987; Taylor-Gibbs, 1989; Sue & Sue, 1990; Lum, 1992).

As suggested earlier, vocational rehabilitation programs can build accountability into the knowledge base by identifying specific knowledge needed to work effectively across cultures. professionals to serve people of different cultural orientations. Yet knowledge and awareness are not enough. Behavioral changes will be needed to operationalize cultural competence. These prospective changes necessary to give life to the concept may provide an opportunity to build accountability into staff performance and agency administration. The five principles associated with the CASSP cultural competence model can begin to suggest areas in which accountability might be designed. The five principles and a brief discussion of opportunities to build in accountability are listed below:

1. **Developing a Value for Diversity**. This area suggests professionals, agencies, and systems must go beyond slogans. They need to find concrete ways of exemplifying a value for diverse clientele, staff, board members, consultants, and volunteers. The emphasis upon respecting cultural choices, histories and destinies, beliefs and practices, and community goals of the various cultures.

The range of activities will vary depending upon the cultural competence of a given agency. Agencies that are new to the concept may do the groundwork of meeting with cultural key informants and initiating talks about cultural competence. A more culturally advanced agency might assure that diverse people are depicted on agency brochures, put ethnic art in the lobby, or identify community based resources. An even more advanced agency might take steps to stay abreast of changing populations, recruit and retain diverse staff, or acknowledge cultural holidays. And perhaps an even more advanced agency might begin to perform cross cultural trainings, conduct cultural research, design or convene rights of passage programs, or collaborate with leaders of a given ethnic community (Isaacs & Benjamin, 1991).

Action must begin to replace words or thoughts. Yet, holding every agency to the same standard may be inappropriate. Agencies will be at different points on the cultural competence continuum for different populations and communities. Programs and agencies can be given the opportunity to describe how they will manifest a value for diversity, and develop methods of holding themselves accountable. Sanction, support, or advice on behalf of a given ethnic community can contribute the credibility of the effort.

Indeed, it is important for agencies to describe in concrete terms a value for diversity and how these efforts can be executed, and evaluated.

2. Conducting a Cultural Self-Assessment - This principle stresses the importance of professionals and organizations taking periodic steps to: examine their strengths and weaknesses with the diverse communities they serve; consider the extent to which they view culture as a factor in the helping process; review staff demographics and characteristics; look at service outcomes by cultural group; even, identify the numbers and types of cross cultural staff development or training opportunities personnel have had.

Again, accountability can be built into this concern. Funding streams, bureaucracies, and systems might require that organizations conduct cultural self-assessments. These assessments can reveal how well an agency is prepared to serve the current or projected culturally diverse groups comprising the service area; they may also identify areas of cultural strength or experience previously unknown or unused by the agency (Mason, 1995). Assessments can then be used to design agency-specific interventions that promote even greater competence.

Indeed many opportunities will present themselves, other areas where accountability might be considered include:

1. the periodic administering cultural bias scales to staff,
2. the establishment of a process to mange cross-cultural conflicts
3. the routine use of viable client/consumer satisfaction measures
4. the systematic collection and review of community-based needs assessments, community demographic information, and
5. the means to identify strategies that an agency will use to routine perform cross-cultural self-studies.

3. Understanding the Dynamics of Difference - This principle concerns the interactions and behaviors that may transpire when individuals from different cultures interact. Growing out of the concern for cultural self-assessment, this concept holds that agencies anticipate and address the potential frictions that can occur cross culturally. Agencies can hold themselves accountable for helping new staff communicate and mediate conflict cross culturally, and they may also help staff consider how they view and are viewed by others.

In particular, staff can be made familiar with potential sources of conflict or situations that may produce tension. However, the ce of this concern behaviorally is assuring that staff have the interpersonal skills or other structures to educate or mediate around such issues. These conflicts can occur between agencies and communities. Agencies that do not recognize help-seeking behaviors, social histories, or other socioeconomic realities of a given culture may be inadvertently setting themselves up for trouble. This will be particularly true for agencies that are inflexible in their policies and impose mainstream cultural beliefs (no matter how sublime) on culturally diverse populations. This principle acknowledges that conflicts are often inevitable when people of diverse backgrounds encounter each other. Yet, agencies must be accountable for anticipating such frictions and have mechanisms of mediating or managing conflicts. Given that many groups have not been well integrated into or understood by the dominant society, cross cultural mistakes are going to occur. The idea is to provide services in a way that allows consumers to express anxieties, frustrations, fears, or other views (real or imagined) that can get in the way of effective and comprehensive service delivery.

4. Accessing Cultural Knowledge - This principle suggests that agencies need approaches for assuring that staff have opportunities for learning about culturally diverse populations, or have somewhere to turn for help when they reach a cross-cultural impasse. Certainly agencies can begin to assemble resource materials that may prove helpful. Agencies can also begin to identify the types of linkages they have and need with respect to cultural key informants -- community advocates, family member organizations, educators, and researchers -- and, go out and develop relationships with these important resources.

The degree to which agencies assure that staff have access to relevant and accurate knowledge may become a criteria for cultural competence in the future. Agencies may build in accountability supporting the cultural competence development of all agency personnel. This may suggest that agency staff may need to outreach to natural helpers, community leaders, diverse consumers and professionals, and others who can serve as cultural guides.

Given that culture is a dynamic phenomenon and subject to change, the ability to constantly update knowledge and skill will prove extremely helpful. Agencies may want to pool resources to assure a more comprehensive cultural informant network.

5. Adapting to Diversity - This principle concerns the specific adaptations professionals and agencies make in order to effectively serve culturally diverse populations. Bear in mind that cultural competence is very contextual, and various issues can determine if a program will be successful or not. Therefore, agencies while learning from others, may need to tailor the new found information so it is relative to their respective situations. For example a program that works effectively with African Americans in Charleston, South Carolina may need to de adapted to have a similar impact on African Americans in the Bronx, New York. Conversely, one cannot rule out that a program working effectively with working class Latino or Hispanic Americans may also have application for working class mainstream Americans.

This notion also implies that vocational rehabilitation, in making adaptations for diverse consumers and communities, may

be able to learn from others working in different but related disciplines.

The four key elements associated with the model are listed below. They are listed in terms of how they may be manifest in a given agency. This list is in no way exhaustive, thus the challenge for the field is to continually identify ways of improving vocational rehabilitation services delivered to culturally diverse populations. The elements are below:

1. Attitudes - this refers to the cognitive aspects of cross cultural service delivery. Workers and agencies must stay vigilant in assuring that staff attitudes are conducive to working cross culturally. Staff will need to learn their own cultural weaknesses and biases, and develop the wherewithal to work on them. They also need to learn of the community and cultural based strengths of the diverse groups so they maintain a positive focus and to involve these structures in treatment services and program design.

To maintain this strengths perspective when working cross culturally, agencies can bring in speakers, consumers, experienced workers, community advocates to help staff develop a positive perspective of the people they are serving.

2. Practices - this element is also supported by a great deal of theoretical and research literature. Agencies should require that cultural competence is considered in all staff and consumer interactions. Not just in cross cultural situations or among mainstream staff.

Staff can learn from a variety of (former) consumers as what went well and what did not. Staff can learn from the field about state-of-the-art practices (e.g., culturally-specific diagnostics and assessment approaches, culturally competent service delivery models, culturally informed evaluation). Information is constantly being updated to improve clinical practices and administrative procedures. Many programs have used practice review mechanisms involving consumers and advocates (Isaacs & Benjamin, 1991).

3. Policies - this is an area that is important for upholding any changes. This would suggest agencies examine policies concerning:

4. recruitment and promotion practices,

5. mission, goal, or vision statements

6. service utilization and customer satisfaction reviews

7. outreach efforts and venues

8. interagency linkages (with formal and informal support systems)

9. cross cultural conflict management, and

10. consumer involvement (at diverse levels)

When the sound practices and attitudes of a work force are not upheld by formal policies, good practice and other behaviors can fade in funding cuts, new priorities, new leadership, or new staff. Further, much of the information regarding culture, race, and gender contained in current policies, grew out of the civil rights eras of the 60's and 70's. While often relevant, they need to be reviewed and updated to facilitate cultural competence to accommodate new groups and issues.

6. **Structures - this element has two dimensions**. One concerns the governing structures of agencies, and the second concerns the physical structure. With the former, agencies can consider building in accountability as to who is on the board, who is hired as consultants, advisors, or subcontractors. Agencies can begin to identify ways to have diverse communities participate in the economy generated through the provision of services.

Equally important, people that are identified should not be used simply because they are racially or linguistically similar to the target population being served. Nor because they are easy to work with in a professional capacity. Instead, they should have some ties to the culture or community if they are to improve agency practice and service delivery.

Physical plants can begin to take on non-stigmatizing or even inspiring names (Isaacs & Benjamin, 1991). The physical plant also needs to be amenable to the access, child care, and transportation issues of its clientele.

Conclusion

Cultural competence as a concept is a very flexible and forgiving concept. The cultural competence continuum (Cross, et al., 1989) suggests that it is not important where an agency starts, but where its going. With this in mind, it is appropriate for agencies, prior to the imposition of generic cultural competence standards, to develop agency-specific accountability measures. That means that vocational rehabilitation programs will have to outline the ways they will exemplify the concern for cultural competence and how they will be accountable.

In the early stages of this transformation to cultural competence, agencies may need to be given the latitude to define how they will deliver culturally competent services. This will be tied to their current situations, resources, and abilities. Agencies will need to consider the populations served, the agency-based cultural strengths and resources in place, and their service objectives.

Agencies should be proactive in pursuing accountability. Undoubtedly as populations change, vocational rehabilitation systems and bureaucracies will be asserting cultural competence. Unless agencies have plans, activities, and accountability measures in place, some may be externally imposed. Not stated strongly enough in this discussion, is the potential allies that exist. Many people have a stake in service provision. Consumers, family members, community advocates, and other cultural key informants and natural helpers need to be a part of this decision-making process. With a little support, various individuals can play vital roles in the design of culturally competent systems of care.

Without accountability, the concern to provide culturally competent services may be relegated to words. Words may stave off community concerns initially, however, as communities become more involved and informed they may desire more comprehensive change. Also, in a managed care environment, competition may be heightened. Customers may opt for programs that have taken on the challenge of culturally competent service provision in meaningful ways. Vocational rehabilitation, like many other disciplines, will be faced with diverse customers and clients in the future. Building in accountability now may be the strategy that keeps agencies viable well into the 21st century.

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In the broader context, practitioners owe it to the persons they serve to be culturally competent. The demographics have changed and will continue to change, as well as, the renewed focus on working with individual consumers from a "wholistic" perspective. A culturally competent rehabilitation professionals provides another potential vehicle to achieve accountability. Defining the "culturally competent" rehabilitation professional has raised many issues and created much controversy.

Over the last three (3) decades, the profession has been struggling with how to adequately prepare rehabilitation professionals to be culturally competent and how we can measure or evaluate the level of cultural competence. A review of related literature on professionals who provide effective service has indicated that there is some credibility to support the paradigm that the provider be culturally competent and culturally specific. However, issues do not come without questions to be answered. Some of those question include: Who will decide what culturally competence is? (a) What attitudes, values, and beliefs are necessary? (b) what core knowledge should be acquired? and (c) what skills need to be learned and when they should be applied?

The profession, along with all of its supporting components, have an obligation to work from a culturally sensitive foundation. In order for the practitioner to be culturally competent: the training programs (graduate, distance learning, inservice, etc.) must have the curriculum which transcends the philosophical understanding and incorporates those most significant elements which are culturally specific. The accreditation bodies' criteria must make cultural competence an integral part of the standards with reinforcement power, to improve the preparation of culturally competent rehabilitation professionals (i.e.) who can develop culturally specific programs, and deliver culturally sensitive services. In addition, rehabilitation research must be "inclusive" and address diversity issues and they relate to the practical application and implementation of the y competent professional practices. Finally, the profession must assume responsibility to assure that all parties involved in the provision of services will be culturally competent.

Eddie E. Glenn

The key question for the author of this article is in the field of rehabilitation what do we mean by cultural competence? The author speaks of cognitive as well as behavioral expectations for cultural competence but are we truly examining cultural competence when namely, a counselor regardless of their race or gender serves consumers from diverse populations in an approved and acceptable manner and have positive outcomes that meet all intended parties criteria for performance? This is the paradigm the article alludes to. Namely, the human ability of professionals to render services to those seeking assistance in a manner that is respective, unbiased, and unconditional in their regard for another human being. We train professional to treat others in the manner to which they have been treated. How do we fix it if our treatment of each other is less than desirable? Its not seeing beyond the other's behavior, its not closing our eyes to it and tolerating it. It is communication and discussion to gain an understanding. Our professional code of ethics expects the rehabilitation counselor to function this way and no other. Our organizations don't always support behavior, as systems and procedures can be entrapments for hiding behind or given as excuses.

Geraldine Hansen

The issue of vocational rehabilitation and cultural competence is one of importance and deserves attention in the discussion of accountability. The growth of diversity in the population necessitates discussion of the issue, conscious acknowledgment, behavioral changes and strategic planning to actualize development of all human potential. I subscribe to the melting pot theory of our nation's growth and development. I believe in the sociological dynamic of assimilation. By the fifth definition of culture according to the Webster's New Twentieth Century Dictionary, it is the study of a science or art for the purpose of making amendments or improvements therein. I agree that integration of cultural competence and accountability is a necessity. I appreciate and honor diverse communities and populations, which establish, express, and celebrate their own identify. This deserves attention and promotion. In contact with leaders of independent living movement, I have become aware of the concept of disability pride. The goals of independence, skill development, and employment remain primary to the field of rehabilitation with an understanding of the cultural elements of family, roles, values, and language. Training programs that educate, provide for introspection, and develop plans of acts to increase and promote cultural competence in proving rehabilitation services need continued development. Research may track access, utilization, outcomes and satisfaction to develop strategies to meet the needs of unserved and under served populations. Cultural competence as stated in this paper is a development concept. I feel the historic underlying barrier to the development, acceptance and integration of cultural diversity lies in the white male dominant power structure of nation. In my work with Boards of Directors, it is and has been a priority in seeking the best person for membership to search for qualified women, minorities, and people from diverse backgrounds represented in the community. The review of agency policies in strategic planning is an excellent arena for implementing cultural competence. I think that the initiative of legislation has clearly had an effect in promoting cultural competence. A review of present initiatives may be valuable. Lastly, I do believe that there is something of a historical account of and for culture and that present societies are responsible for inequities and "sins" of the past.

Kevin F. Manning

Understanding cultural competence and acknowledging the need for this level of awareness and involvement is clearly critical to the life and well-being of vocational rehabilitation programs across this country. The issue of responsibility extends far beyond the

Rehabilitation Act of 1992, specifically Section 21 wherein states are required to address the needs of unserved and underserved persons with disabilities from diverse backgrounds. If states respond solely because the law "requires" it, I believe the overriding concept of competence and its importance will be missed

Cultural competence must become a part of an organization's internal culture. It must evolve somewhat naturally so it does not appear to be forced on those who are expected to respond to the needs of consumers with disabilities. One approach is to develop an organizational purpose, values, and philosophy that expresses the vision of the leadership as it relates to cultural competence. This information should not just highlight this subject, but many others, with this as the backdrop.

Leadership is key to this concept's being embraced and demonstrated throughout an organization, and vocational rehabilitation agencies are no exception. Leaders must assure that discussions of competence are undertaken with all leaders within the vocational rehabilitation structure (mid/upper level managers) in an environment that is non-judgmental and open. Further, the leader must articulate an expectation of accountability in the area of cultural competence. Qualified rehabilitation staff from diverse backgrounds, cultures, lifestyles, etc. must be recruited, hired, and promoted to positions of leadership. This model must be put into place and carried out by top leaders and then cascaded throughout the organization so it permeates the entire agency. Data must be collected, maintained, and evaluated to determine progress and areas for change and improvement. This data should be reflective of hiring and service provision. Leadership again must speak to the need for collecting this information, the importance of evaluating the outcomes, as well as the expectation for verification of hiring and service practices.

To help ensure that the awareness of and the expectation for cultural competence with vocational rehabilitation programs is embraced early, leaders should design orientation programs that speak to this. The sooner employees understand the need and expectation, the greater the chances that competency will be a natural part of the organization's life and culture. The subject matter will not be considered an anomaly, unusual, or unexpected. Leadership is key to the success, understanding, and acceptance of cultural competence.

Peggy D. Rosser

1. Recommendations for any areas not categorized in the other five listings below:

- The rehabilitation profession must develop and adopt both a conceptual and an operational definition. of cultural competence.

- The rehabilitation profession must also develop a conceptual and an operational framework for cultural competency which includes affective, cognitive, and behavorial components.

- The cultural competence framework should include the following elements:

    - A definition of cultural competency
    - Strategies to implement the "cultural competency model".
    - A description of the measurement of cultural competence and predefined acceptable standards of achievement.
    - An organizational structure analysis to determine the qualitative level of attainment of cultural competence.
    - The involvement of all stakeholders and use of traditional and cultural specific approaches to include individuals from traditionally underserved and under represented populations.
    - The use of advocacy models which integrate approaches from various disciplines/professions to address cultural competence.

2. Recommendations/implications that would enhance Systems Service Delivery:

- Infuse models that focus on "Systems of Care" (e.g. Georgetown University Model) as described by:

- Design all services delivery systems with an inclusive "outreach systems" approach.

- Establish process to identify and adopt culturally effective "best practices".

- Design and use individual and community focused. service delivery systems.

- Establish culturally responsive, customer friendly, accessible, and usable service delivery systems (e.g. interpreters, resource list, peers who are knowledgeable, systems of delivery that are culture specific).

- Use culturally competent support structures to enhance the client counselor relationship and throughout the entire process (e.g. intake - placement - follow-up).

- Involve stakeholders representing the various groups in the community in the development, planning, implementation, monitoring and evaluation of service delivery systems and in appropriate settings at all levels.

3. Recommendations for Program Development:

- Inclusion of cultural competence standards that must be met for the accreditation of all programs under development.

- Adaptation of the job matching concept to a Cultural Matching System Development which matches cultural competent personnel to related programs which serve individuals from diverse backgrounds.

- Development and implementation of "culturally effective" conflict management and mediation strategies and interventions.

- Designing and applying "culturally appropriate" qualitative outcome measures.

- Involvement of a representative stakeholder group at all levels in the process of program development.

4. Recommendations for Education and Training:

- The development of national standards of cultural competence and mandatory inclusion (especially for accreditation) in all education and training provided by all institutions, organizations, and agencies with delivery rehabilitation related services.

- The development of guidelines to promote cultural competence as essential components in professionalism, credentialing, and regulation.

- Utilization of a cultural competence developmental continuum approach in all preservice education, inservice training, and continuing education activities which includes the three cultural competence components: (i.e.) a) affective - values, beliefs and attitudes; b) cognitive - knowledge, and c) behaviors - skills at all levels (i.e.) beginning, intermediate and advanced.

- Require that all education and training activities address the following issues relevant to cultural competence:

    - Awareness of one's own world view; impact of personal values, beliefs and attitudes on ability and willingness to work effectively with culturally diverse individuals.
    - Cognitive; a knowledge of the strengths, behaviors and traditions of different cultures.

- Behavioral (skills); the application of skills and knowledge in a culturally effective way.

- Require that curricula, training materials, resources and experiences reflect the needs of the consumers and meet culturally competent professional, ethical, and legal standards.

- Expand training and preparation toward more philosophical/sociological/ecological foundation, and "holistic" approach to program development and service delivery.

- The establishment of accreditation standards which identify those cultural competencies to be taught and measured.

- Requirements that cultural competence be demonstrated in clinical field practices (e.g., practicums and internships).

5. Recommendations/implications for needed research:

- Conduct and expand research on emerging congenital, developmental, and acquired disabilities and related issues; e.g., culture and poverty, violence, drugs, nutrition; the impact of culture; disabling conditions predominated by culture; attitudes among and within cultures towards "mainstream" culture and each other and their impact on service delivery.

- Conduct research that provides information and data on specific educational and developmental needs of individuals from various cultures (e.g. language, learning styles, etc.).

- Identify and promote research on relevant issues that promote and facilitates implementation of cultural competence.

- Identify research issues that are culturally specific.

- Disseminate information that is culturally accessible for utilization by different cultures and targeted individuals, groups, communities, professionals, and agencies.

- Research to identify the relevant indicators for successful outcomes which are culturally specific.

6. Recommendations/implications for Policy (Legislation: Federal, State, Local):

- Include in all Rehabilitation Services Administration grants and other related funding sources a requirement that "cultural competence" be addressed.

- Continue to promote the designated funding of culturally specific projects.

- Continue to promote policies that are culturally appropriate.

- Develop culturally sensitive regulations which allow rehabilitation professionals to customize (tailor) service delivery, rules to be responsive to consumers/individuals with disabilities from diverse cultural backgrounds.

- Include "focused policy" that specifically address funding to increase resources and access to services for the impoverished and those individuals whose life cycle is rooted in a system of "cultural" poverty - poverty is a culture within and of itself.

- Develop and mandate a policy of "zero" tolerance for overt and covert, discriminatory, prejudicial, and biased practices.

- Develop policy to require advocacy representatives from diverse cultural backgrounds.

- Support advocacy for programs/policies or early intervention services for the poor and those individuals who are affected by the culture of "poverty" (e.g., impact of current or future disabilities by advocating for programs that support those without funds and resources to assure early intervention, prevention and treatment).

- Develop policies which promote and assure "cross disciplinary" advocacy efforts.

- Develop policies that mandate for staff development and evaluation of cultural competence for improvement and effectiveness.

- Establish policies which make mandatory staff development programs in cultural competence, and require the measurement of existing programs and services toward demonstrated improvements in the delivery of culturally effective service delivery.

- Eddie E. Glenn

Research: Areas of Accountability Issues

Dr. John Westbrook

First hand, I know that research takes time. I know that research is messy. I know that research is not cheap. I know that research requires team work. I also know that if we are deliberate, if we are patient, if we are persistent, if we share what we learn, the quality of life we are able to offer individuals with disabilities will be changed for the better.

Senator Bill Frist, Chair, U.S. Senate Subcommittee on Disability Policy, 6/7/95

Introduction

People value research differently depending upon their ability to use it. Evidence (NCDDR, 1996, NCDDR 1998) suggests that people with disabilities and disability service providers generally value disability research. Research currently being performed in the rehabilitation field addresses a wide variety of topical areas. The outcomes of rehabilitation research are generally available to other researchers, rehabilitation (and related) service providers, disability policy makers, and people with disabilities and their families.

It is difficult to envision a case in which the intended ultimate beneficiaries of rehabilitation research should not be people with disabilities and their families. One might contend that a general accountability exists to ensure that rehabilitation research outcomes clearly benefit consumers of rehabilitation services.

In the real world, however, multiple and overlapping accountabilities exist in the rehabilitation research arena. Our purpose in this paper is not to define how rehabilitation research should be designed and performed but rather to describe current critical accountability issues that significantly influence today's rehabilitation research and its impact on intended audiences. It should also be clear that rehabilitation research is capable of influencing scientific knowledge as well as shaping our understanding of the nature of current and emerging disabilities in the world of tomorrow. In short, rehabilitation research spans a wide universe from medical to secular arenas.

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What is rehabilitation research? The National Institute on Disability and Rehabilitation Research (NIDRR) defines rehabilitation research activity in the following manner (Federal Register, February 6, 1997).

> In carrying out a research activity under this program (the Disability and Rehabilitation Research Project and Centers Program), a grantee shall --
>
> (a) Identify one or more hypotheses; and
>
> (b) Based on the hypotheses identified, perform an intensive systematic study directed toward --
>
> (1) New or full scientific knowledge; or
>
> (2) Understanding of the subject or problem studied.

This definition recognizes a continuum in research from basic to applied forms. These types of research are significantly different and are also differentiated by NIDRR (Federal Register, February 6, 1997) in the following manner:

- Basic research is research in which the investigator is concerned with primarily gathering new knowledge or understanding of a subject without reference to any immediate application or utility.

- Applied research is research in which the investigator is primarily interested in developing new knowledge, information or understanding which can be applied to a predetermined rehabilitation problem or need. Applied research builds on selected findings from basic research.

The majority of current rehabilitation research is of the applied research variety. Most of the priorities and descriptions of needed rehabilitation research emanate from a perceived problem.

Accountabilities in the Rehabilitation Research Area

Responsibilities in the process of rehabilitation research tend to be more complex than singular and straightforward. The process of rehabilitation research potentially involves a variety of individuals especially when considered comprehensively from the research agenda planning stage to its ultimate use by intended tar-

get audiences. Multiple parties often share accountabilities in the implementation of these major research process areas. It is also the case that specific accountabilities are less than clear when considering the influences that affect the "big picture" of rehabilitation research in America today.

Clear accountability systems and associated measureable progress data that address all activities of rehabilitation research do not appear to currently exist. Mechanisms for achieving consistent measurement and appraisal of America's rehabilitation research effort, likewise, are less than clear.

For the purposes of this paper, accountability generally refers to the process by which an individual or an organization assumes responsibility for an activity and collects/provides data regarding progress in meeting or exceeding expectations associated with the responsibility. Accountability necessarily involves the formal or informal assessment of accomplishment in meeting real or perceived expectations.

At a minimum, major areas of accountability issues in the process of rehabilitation research appear to involve:

1. planning and coordinating the national agenda of rehabilitation research,
2. funding of rehabilitation research,
3. ensuring high quality of research outcomes,
4. demonstrating applicability of outcomes to rehabilitation services,
5. disseminating rehabilitation research outcomes to its intended beneficiaries, and
6. applying rehabilitation research outcomes in real world situations.

The following sections address these accountability issue areas in more detail.

1. Establishing the National Rehabilitation Research Agenda

A number of Federal entities are involved in shaping the national agenda of rehabilitation research. This condition, when viewed from the researcher's perspective, blurs accountability due to the external influences dictating the scope and nature of what is chosen for research study.

A significant portion of rehabilitation research is publicly funded. A variety of Federal entities are currently funding rehabilitation-related research activities (Institute of Medicine, 1997; Seelman, 1998). These include: the National Institute on Disability and Rehabilitation Research, the Veterans Administration, the National Center for Medical Rehabilitation and Research, the Centers for Disease Control and Prevention, the National Science Foundation, the Architectural and Transportation Barriers Compliance Board, the U.S. Department of Health and Human Services, the Social Security Administration, the U.S. Department of Housing and Urban Development, and the U.S. Department of Transportation.

The Need for Coordination

Clearly, with so many Federal agencies involved, a need exists for coordination to achieve a national agenda for rehabilitation research. Perhaps because of its major role in conducting rehabilitation research, NIDRR was given the responsibility to convene and chair the Interagency Committee for Disability Research.

> The Interagency Committee on Disability Research (ICDR) is authorized by Section 203 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 761b. The statute establishes the ICDR with the mission of promoting coordination and cooperation among Federal departments and agencies conducting rehabilitation research programs. The Director of the National Institute on Disability and Rehabilitation Research (NIDRR) is designated to chair the ICDR. (Seelman, 1996.)

At the current time, the ICDR official membership represents Federal departments or agencies and selected national organizations due to their work and/or interest in the area of disability research. In addition, other agencies and national organizations also participate in the ICDR activities that conduct direct efforts related to rehabilitation research. As of June 1998, ICDR participants included the following major entities.

Members of the ICDR include:

- Director, National Institute on Disability and Rehabilitation Research, U.S. Department of Education (Chair)
- Commissioner, Rehabilitation Services Administration, U.S. Department of Education
- Assistant Secretary, Office of Special Education and Rehabilitative Services, U.S. Department of Education
- Secretary, U.S. Department of Education
- Secretary, U.S. Department of Veterans Affairs
- Director, National Institutes of Health
- Director, National Institute of Mental Health
- Administrator, National Aeronautics and Space Administration
- Secretary, U.S. Department of Transportation
- Assistant Secretary, Indian Affairs, U.S. Department of the Interior
- Director, Indian Health Service
- Director, National Science Foundation

Additional agencies and organizations participating in the ICDR include:

- Administration on Aging
- Administration on Developmental Disabilities
- Agency for International Development
- American Academy of Physical Medicine and Rehabilitation
- Architectural and Transportation Barriers Compliance Board
- Bureau of Labor Statistics
- Bureau of the Census
- Centers for Disease Control and Prevention
- Committee for Purchase from People Who are Blind or Severely Disabled

- Department of Defense
- Department of Energy
- Department of Health and Human Services
- Department of Housing and Urban Development
- Department of Justice
- Department of Labor
- Department of State
- Equal Employment Opportunity Commission
- Federal Communications Commission
- General Services Administration
- Health Care Financing Administration
- International Association of Business Industry and Rehabilitation
- National Center for Health Statistics
- National Center for Medical Rehabilitation Research
- National Council on Disability
- National Institute on Deafness and Other Communication Disorders
- National Parent Network on Disabilities
- Office of Management and Budget
- Office of Special Education Programs, U.S. Department of Education
- Paralyzed Veterans of America
- President's Committee on the Employment of People with Disabilities
- President's Committee on Mental Retardation
- Social Security Administration

The ICDR and its specialty-area subcommittees addressing: disability statistics, medical rehabilitation, and technology reflect a potentially positive instrument in meeting the agenda coordination challenge. Its existence and constitution highlight an important accountability issue in rehabilitation research -- who should set and coordinate the national agenda of rehabilitation research?

One must question whether there is a known Federal rehabilitation research agenda. If so, is there coordination among the array of Federal entities that fund rehabilitation-related research and/or the number of agencies that participate in the ICDR? A national rehabilitation research agenda could shape the topics, scope, and parameters of research across agencies both Federal and private. However, without a clear and well-known national research agenda significant benefits may be lost.

The ICDR, through its Chair, regularly reports on the status of rehabilitation research. In the last Report to the President (Seelman, 1996) the following remarks were noted:

- The scope and content of disability research is expanding so rapidly that Federal efforts to fund, promote and disseminate the research are greatly in need of coordination and collaboration, (p. 2)

- The ICDR is the vehicle established to help all Federal agencies who fund disability research to: avoid duplication of effort; identify gaps in research; identify opportunities for collaboration; develop mechanisms for collaboration; promote synergy through combined resources; and share information, activities, and research findings in order to build a more systematic and cohesive Federal effort (p. 2).

The extent to which the national agenda for rehabilitation research should be broadly or narrowly cast depends upon one's frame of reference. It is not difficult to find vocational rehabilitation professionals that argue for the bulk of attention and benefit from government-funded rehabilitation research to be focused on the improvement and enhancement of the rehabilitation process. Others have espoused a broad focus on disability research issues including projected issues not directly affecting the current day-to-day activities of vocational rehabilitation counselors, for example. The breadth, depth, and scope of the disability/rehabilitation research agenda significantly affect the nature and intensity of research-based results information available for application.

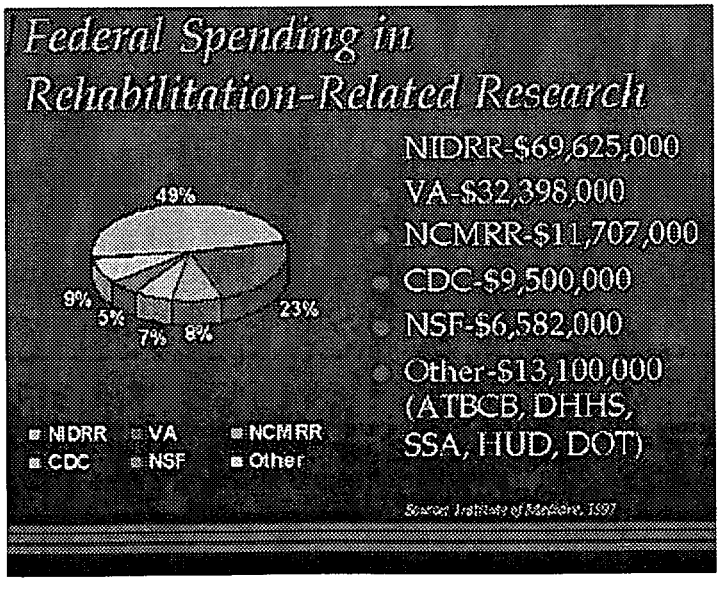
Is it better to research a few rehabilitation-related areas intensely or to research a variety of areas in less depth? What are the parameters of rehabilitation research? Who should have the strongest voice in shaping the national rehabilitation research agenda?

2. Funding Rehabilitation Research

Given the case that the Federal Government strongly influences what will be researched in rehabilitation through its determination of research topics and associated statements of research priorities, it is also the case that this process strongly influences how rehabilitation researchers approach the establishment of their research design. Amazingly, applicants for research dollars often find no difficulty in massaging a research design into a somewhat arbitrary three or five year timeline. Longitudinal studies are a rarity in many areas of rehabilitation research. The timelines for research project periods significantly affects timeliness and availability of needed research-based information.

According to funding data (Seelman, 1998), the following represents the recent general distribution of rehabilitation-related research expenditures.

Figure 1



This figure shows that the National Institute for Disability and Rehabilitation Research (NIDRR) is responsible for almost half of the rehabilitation-related research expenditures, followed by the Veterans Administration with 23 percent, the National Center for Medical Rehabilitation and Research (NCMRR) with eight percent, the Centers for Disease Control and Prevention (CDC) with seven percent, the National Science Foundation (NSF) reflects five percent of the expenditures, and nine percent is expended by other Federal agencies including the Architectural and Transportation Barriers Compliance Board (ATBCB), U.S. Department of Health and Human Services (DHHS), the Social Security Administration (SSA), the U.S. Department of Housing and Urban Development (HUD), and the U.S. Department of Transportation. These data indicate a total annual expenditure across these agencies of approximately $143,000,000 on rehabilitation-related research.

Rehabilitation researchers have expressed a need for increased funding for major rehabilitation research efforts. Federal agency managers involved in rehabilitation research have indicated that the funding for rehabilitation research is not keeping pace with cost of living increases.

How much funding should be devoted to rehabilitation research? How should the funding be allocated between the multiple agencies involved in rehabilitation-related research? Should fewer agencies with more resources be responsible for rehabilitation research? Is funding the most important factor determining the ultimate quality and utility of rehabilitation research outcomes?

3. Quality Assurance in Rehabilitation Research

Significant effort goes into the initial planning and design of rehabilitation research due to the fact that Federal funds are most frequently competitively awarded through an objective peer review process. While the selection criteria for these competitions vary widely, each is aimed at clarifying and critically appraising the soundness and value of the research proposed. Ideally, the use of such an objective review process serves to improve the quality of the research that is conducted.

At the current time, however, an interesting phenomenon occurs after an applicant is funded for a rehabilitation research effort. After award, rehabilitation researchers receive little in the way of "quality" monitoring. Researchers perform activities that may or may not have been detailed in their proposal of work. NIDRR, however, has recently begun to perform program reviews on selected larger rehabilitation research projects it funds.

Most frequently, rehabilitation research results are treated as being of equal importance, value, and quality. While the nature of "quality" of research is highly debatable, most researchers agree that the soundness of research designs and the way in which those research designs are implemented, affect the quality of the findings. Clear ways to "rate" research results for use in the application process is non-existent. Critical reviews of rehabilitation research findings generally do not take place outside of academic/professional peer reviews that occur when seeking publication of research results in refereed, scholarly journals.

Philosophical strategies such as Participatory Action Research (PAR) (Turnbull & Friesen, 1995; Turnbull & Turnbull, 1996; Salcido, 1997) and Constituency-Oriented Research and Dissemination (CORD) (Fenton, Batavia, and Roody, 1993) have been used in some rehabilitation research settings to more clearly and routinely involve people with disabilities (the presumed users of research) in the planning, implementation, evaluation, refinement, and dissemination activities of rehabilitation research projects. People with disabilities have played various roles in these quality assurance strategies. Opinions vary about the effect of these strategies due to the variety of ways in which they are implemented across research projects. Some researchers argue that the intended end-user of their rehabilitation research outcomes is not always people with disabilities and their families. The way in which strategies such as these are implemented affects the resulting benefit of them in shaping and sensitizing the rehabilitation research processes established within individual research projects.

Who is responsible for the quality of the outcomes of rehabilitation research? Can the criteria for rehabilitation research quality be uniformly stated and measured? Should quality be determined by each researcher?

4. Demonstrating the Utility of Rehabilitation Research Outcomes

The usefulness of rehabilitation research findings is often determined by the extent to which the results are understood. Rehabilitation researchers are infrequently required to demonstrate how their findings can be applied in the real-world rehabilitation service delivery process or in the day-to-day lives of people with disabilities.

Seldom, if ever, do research designs include a secondary phase -- demonstrating the application of the results within the service dimension. Such demonstrations would assist in clarifying the application of the research results, the "stability" of the research finding in producing an expected outcome, and the creation of a "laboratory" that can be used by others interested in learning and applying selected research results. Without such routine demonstrations, the implications of certain research may be too vague in the minds of practitioners or consumers to apply. In addition, demonstrations of the conditions under which research results produce expected outcomes can be helpful in clarifying understanding.

Rehabilitation service providers frequently require this level of hands-on information along with an understanding of cost implications, prior to a serious consideration of adopting or adapting their current service systems. Applied rehabilitation research designs encourage the use of research outcomes in solving existing problems or improving current conditions. Additionally, such applications could be useful in coalescing what may be divergent research outcomes into focused demonstrations that combine research emanating from multiple research projects.

Are individual researchers in control of all aspects of their research project? Should consumers and their families have more powerful and informed positions in determining quality and use of rehabilitation research outcomes? Who should be responsible for demonstrating the application of research outcomes?

5. Disseminating the Outcomes of Rehabilitation Research

The National Center for the Dissemination of Disability Research (NCDDR, 1996; NCDDR, 1998) has reported, based on archival data collected and reported by the National Rehabilitation Information Center, the patterns of dissemination exhibited and reported by NIDRR grantees. Figure 2 demonstrates the relative distribution patterns.

Figure 2

Program Area	FY 93 Percent	FY 94 Percent	FY95 Percent	FY96 Percent
Journals	22.3	30.8	4.5	26.7
Mediated Materials	8.4	5.0	11.4	7.8
Reports	7.0	3.7	9.8	6.8
General Awareness	24.3	26.2	21.6	17.9
Books, Chapters, Papers	20.4	21.7	24.0	34.4
Training Materials	4.7	6.3	7.4	4.1
Miscellaneous/Unclassified	12.9	5.8	0.05	2.0
Aids/Devices	0	0.4	0.6	0.1

Summary of Product Types Reported by NIDRR Grantees for Fiscal Years 1993-1996

These data show growth in the dissemination formats of (1) journals, and (2) books, chapters, and papers. These types of dissemination formats appear to be consistent with traditional academic publication patterns exercised widely in the academic research community. These forms of documentation, however, are not to be confused with a user-oriented dissemination plan or strategy.

Questions regarding who should be the intended audience of dissemination practiced by rehabilitation researchers continue. Arguably, the traditional and current primary method of dissemination practiced by rehabilitation researchers would seem to predominantly address the audience of other academics and fellow researchers. These dissemination patterns seem to be less effective in reaching direct rehabilitation service providers and consumers of those services.

Fuhrman (1994) has noted that "understanding client needs is a complicated business if it is taken seriously" (p. 135). This complicated business becomes even more complex when one considers the "cultural pluralism" perspective, that is, when "persons with disabilities are seen as multifaceted individuals with important similarities to those without disabilities" and who come from varied backgrounds. Minority persons with disabilities are often cited as being underserved. Such underservice or non-linkage with existing service systems likely means that they may not receive information regarding rehabilitation research outcomes in the way those using various service systems would. This situation would seem to argue not only for dissemination of rehabilitation research results as presented earlier but also for special outreach efforts that are effective in meeting the informational needs of minority persons with disabilities and their families. Effective outreach to minority persons with disabilities and their families is Who is responsible for such outreach is much less clear.

Dissemination is a deceptively complex process. Serious accountability issues are raised in considering key characteristics of effective dissemination (NCDDR, 1995).

- Effective dissemination is oriented to the needs of the intended user, tailoring the kinds and level of information shared to the forms and language predominant in the intended user group(s).
- It utilizes a variety of modes, including written information, graphic information, electronic media, and person-to-person contact as resources allow.
- It includes proactive and reactive information -- that is, information that intended users have identified as important and information that intended users may not know is needed to apply or interpret shared information.
- It provides for the "natural" flow between the four levels of the dissemination process: spread, exchange, choice, and implementation.
- It builds upon existing resources, relationships, and networks to the maximum extent possible while building new information sources/resources as needed by intended users.
- It includes sufficient information for an intended user to determine the settings or situations in which the information may be applied most productively.
- It provides linkage to resources that may be needed to implement the disseminated information -- usually referred to as technical assistance.

Research designs do not typically include sufficiently detailed plans for dissemination. Selection criteria of many agencies funding rehabilitation research seldom include emphasis or details to ensure an effective research information dissemination and utilization strategy. Dissemination plans included in research applications should focus upon the utilization of research outcomes through a specified dissemination process by intended target audiences.

To whom do the results of federally-funded rehabilitation research belong? Is there a clear difference between the documentation of rehabilitation research results and the dissemination of rehabilitation research results? Do researchers have a responsibility to disseminate research findings and, if so, how broadly and to whom?

6. Using the Results of Rehabilitation Research

Perceptions of validity, quality, usefulness, and benefit of rehabilitation research outcomes are critical in making personal decisions about utilization. Beyond these considerations, do rehabilitation stakeholders have a responsibility to use what is learned from research?

Rehabilitation researchers have sometimes argued that the conclusion of a research project does not mean "research out-

comes" have been produced. Or, moreover, that the results of the research are ready for application/implementation due to the fact that the research project period has expired. So, who determines when research outcomes exist and when they are ready to use?

Rehabilitation research addresses a highly human-intensive arena. Edwards (1991), Leung (1992) and others have contended that a gap frequently exists between research and its use. The most frequently cited reason for this gap is the lack of communication and cooperation between researchers and their intended "user" audiences. Frequently, researchers do not tend to know their user audiences well and, thus, may fail to understand their needs and concerns and outreach strategies that will be most effective (Fuhrman, 1994).

Should rehabilitation research be directly useable by people with disabilities and their families? Should it be directly applicable by direct service providers?

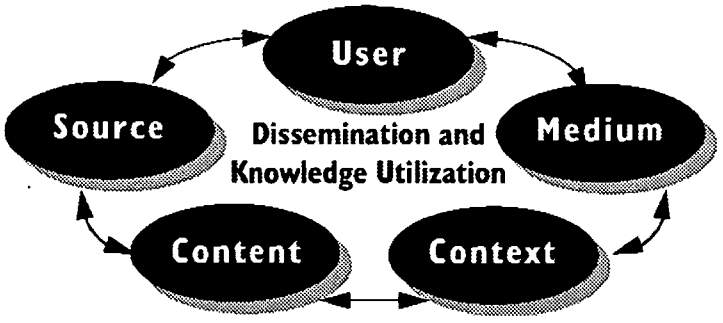
Dissemination and resulting utilization are complex but linked issues. The literature on dissemination and knowledge utilization has been estimated by Leung (1992) as involving some 3,100 publications spread across 18 disciplines. This literature presents varied perspectives on the elements of dissemination/utilization and major accountability issues related to them. Authors generally consider some combination of these five major elements as being critically linked to the overall effectiveness of the dissemination/utilization process:

- the intended user of the information or product to be disseminated;
- the dissemination source, that is, the agency, organization, or individual responsible for creating the new knowledge or product, and/or for conducting dissemination activities;
- the content or message that is disseminated, that is, the new knowledge or product itself, as well as any supporting information or materials;
- the context in which the knowledge or product is developed and disseminated, including contextual factors related to the access or use of the content, source, intended users, and/or medium; and
- the dissemination medium, that is, the way in which the knowledge or product is described, "packaged," and transmitted.

Figure 3 graphically displays the relationship of these elements.

Figure 3

Relationship of Key Elements of Dissemination Leading to Knowledge Utilization



Each of the basic elements of dissemination/utilization are comprised of a series of integrated facets that affect the ultimate utilization of rehabilitation research results. Figure 4 identifies and summarizes elements from the literature that have been demonstrated to be related to utilization. These elements have been used to describe factors related to the use of rehabilitation research outcomes.

It is seldom the case that rehabilitation research dissemination planning addresses these basic elements that are essential if information is to be used. Federal grant announcements rarely require applicants to address these integrated elements as a part of the utilization outcomes expected of dissemination activity plans of rehabilitation researchers. Some argue that researchers can not be expected to do this type of dissemination and other technical assistance, dissemination, and utilization experts should handle this responsibility.

Does the rehabilitation community have a responsibility to use what is learned through rehabilitation research? Is anyone measuring the use of rehabilitation research findings among intended audiences? Are the results of rehabilitation research clear enough for others to assist in promoting their utilization?

Conclusion

A need exists to clarify roles and responsibilities associated with the planning, funding, implementation, dissemination, and utilization of rehabilitation research. Research in the field of rehabilitation offers great potential to assist in solving rehabilitation-related service problems and contributing to the larger body of scientific knowledge. A significant need exists to coordinate the national rehabilitation research agenda in order to meet the needs of both people with disabilities and practitioners in the rehabilitation process. Individual rehabilitation researchers bear significant responsibilities in conducting high quality research designs. On a larger scale, however, the rehabilitation community bears responsibility for shaping, supporting, and funding research. Turning rehabilitation research into practice remains a needed commitment of researchers, practitioners, and consumers alike.

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Figure 4
Factors Related to the Utilization of Rehabilitation Research Outcomes (RRO)

Factors	Issue Related to Utilization
Intended User	• User's Readiness for Change
	• Format and level of RRO Information required
	• Level of contextual information needed to implement RRO
	• Perceived relevance to own needs
	• Dissemination media preferred and required accessibility needs
	• Trust and confidence in the RRO information source
Source	• Perceived competence in providing high quality RRO information
	• Credibility of associated experiences of others
	• Motives are not perceived to be self-serving
	• Perceived sensitivity to intended user's needs and concerns
	• Relationship to other sources trusted by intended user
Content	• Credibility and quality of rehabilitation research methodology
	• Face validity of RRO
	• Comprehensiveness of RRO
	• Perceived utility and relevance in the life of the intended user
	• Capacity to be described in terms understandable to intended users including language/accessibility needs
	• Perceived cost-effectiveness of RRO implementation
Context	• Relationship of RRO with existing knowledge
	• Relationship of RRO to current issues/needs in the field or daily lives of intended users
	• Existence and credibility of competing knowledge
	• Extent of restrictions placed on access to RRO information
	• Economic requirements to benefit from or obtain RRO
Medium	• Physical capability of reaching intended users
	• Timeliness and responsiveness of the RRO information
	• Accessibility and ease of use
	• Flexibility
	• Reliability
	• Credibility
	• Costliness of access or use
	• Clarity and attractiveness of the RRO information "packaging"

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My father was a process development engineer at Dow Chemical for 45 years. His job was to take a chemical process that showed clear promise in the laboratory at Dow, and make it a commercially viable one in an actual plant. I learned many lessons about the realities of research, and the struggle that is the implementation of that research, from him. At least some of those are applicable to rehabilitation research and the issues that Dr. Westbrook has discussed in the relationship between basic and applied research.

One is that, absent a powerful incentive to the researcher to place basic research within the universe of use to rehabilitation customers, research will drift toward what is important in academic institutions and their political and career dynamics. Since research dollars could have been spent for the rehabilitation of roughly 10,000 actual human beings, this is a serious concern. The effort to create and critique a national research agenda is laudable, but I fear that the body devised to accomplish this goal would as likely reflect the distance from customers, as reduce that distance.

As difficult and time consuming as it might be, some form of participatory research that tried to map relations between the needs of customers and the current state of knowledge seems to me to be the very first thing that should be funded with research dollars. Michigan's assistive technology project embarked on a "market analysis" of the hearing aid market using deep focus groups with users, distributors and manufacturers, and we discovered some astounding things. We hope to use this information in collaborative advocacy with customers to change the incentives in the market. I have been, frankly, amazed at the relevance of the results to advocacy and intend to use a similar approach to do strategic advocacy planning in other arenas.

Norman G. DeLisle, Jr.

Dr. Westbrook's discussion frankly and pointedly addresses the current status quo in rehabilitation research, blemishes and all. The dissemination of the results and outcomes of such research is asserted to be offered to the parties that use it and this engenders, at least, some degree of general accountability. It is noted, however, that "in the real world" there are multiple and overlapping accountabilities.

Dr. Westbrook states that "it is difficult to envision a case in which the intended ultimate beneficiaries of rehabilitation research are not people with disabilities and their families". It is, perhaps, unfortunate that I can indeed envision such research. Indeed, a great sense of urgency exists, given the paucity of quality research in this area. It is a reality of being a person with a disability that one must go through at least initial documentation of the functional consequences of disability to gain access to many services and benefits. This is also true of those non-disabled individuals who are subsequently injured through no-fault of their own and must sometimes seek legal remedy. I would strongly assert that this is an area in which the paucity of research compromises the process itself and the accountability of those who conduct vocational assessments within the litigation context or in administrative procedures.

For many years, I have argued that those involved in forensic rehabilitation need to incrementally establish a research foundation upon which responsible decisions may be made. Similarly, those involved in interfacing with various compensation systems need to scrutinize the process and its outcomes and otherwise hold themselves personally and corporately accountable. For many reasons, this is proven difficult for practitioners; even for those practitioners who would welcome such accountability.

Just as some nebulous "agenda" may impact federal funding of rehabilitation research, some forensic practitioners elect not to answer to higher authority or to subject their practices to formal archived documentation. I believe, however, that unless we ourselves assume an accountability that the public can trust in, we will be subject to being held accountable to inadequate, artificial and potentially arbitrary standards set by industry outsiders including attorneys or the judicial system itself. The grave decisions we render and the many impacted by our professional judgments warrant a substantive accountability, and I know I do not stand alone in welcoming it.

Craig L. Feldbaum, Ph.D., CRC

The author provided an excellent overview of research accountability issues. I would like to focus on one aspect - research dissemination to the vocational rehabilitation community because a major problem is lack of a comprehensive, effective method for encouraging VR managers and practitioners to take full advantage of available research.

I agree with Dr. Westbrook that currently there is little systematic measurement of research utilization at an operational level- particularly in the vocational rehabilitation program. Some research and training centers labor mightily on dissemination and utilization, but in their specialized areas.

The institutional mechanisms for disseminating research findings to the VR community need to be evaluated to determine their overall effectiveness. Different dissemination models need to be tested.

One example of an extremely effective research dissemination model is the Department of Agriculture's Agricultural Extension program. County agents, supported through land grant universities, transferred the findings of agricultural research to their local farmers. These were individuals well-versed in both the latest research and the needs of their local farmers. Perhaps a comparable model could be developed and tested in the VR community funded by RSA training monies and NIDRR research funds. A network of university-based research dissemination specialists could be established throughout the U.S. with responsibility to disseminate pertinent research to rehabilitation agencies and organizations. - **Harold Kay**

I support the author's perspective relative to the need for a coordinated research effort that ultimately benefits the person with a disability first, and then, rehabilitation practitioners. However, as I reviewed the entire document, including the extensive list of participants on the Interagency Committee on Disability Research (ICDR), I was struck by the absence of any mention of local involvement. In my opinion, the further one is removed from the actual issue(s), the less "real" understanding one has of the issue(s). The research becomes more "academic" than "real" or practical and somewhat more difficult to access.

In addition, one of the greatest benefits of local research and, thus, a benefit to the consumer, is actual results or information from that area that compels legislators and other policy makers to "fund" a program or activity in support of persons with disabilities. My experience, legislatively, has been that politicians care more about what happens in their backyards than in the universe. Therefore, while I favor some national research, it is incumbent on us to give significant focus to research that is region/state/agency specific and use the results to market who we are and the need for additional/continued funding, what we have accomplished and for whom; the obstacles that were encountered, escalating cost and time constraints, quality of the work and subsequent quality outcomes, etc. This, to me, is where the need is and the focus should be.

Peggy D. Rosser

1. Recommendations/Implications on Research Agenda:
To clearly state the national Rehabilitation Research Agenda through outcome and application oriented research goals and designs.

- The focus of all rehabilitation research should be on the intended beneficiaries, central in which are people with disabilities.
- To be most effective the national agenda should address broad economic, social, and health priorities re-focusing the "splintered: agendas of separate funding agencies.
- The research agenda ought to include the collaboration of private and public funders such as foundations and industry.

2. Recommendations/Implications on Stakeholder Input to the National Research Agenda:
To develop a grassroots mechanism to identify the research issues of importance from all people with disabilities, practitioners and other stakeholders.

- Increase and broaden shareholder involvement in the planning, implementation, evaluation, and dissemination phases of research projects.
- Research outcomes should clearly express benefits for all people with disabilities.

3. Recommendations/Implications on Research Principles:
To identify through broad consensus-shaping efforts, a collaborative approach to the funding and implementation of the national research agenda. An example might be strategies that lead to improved service delivery models that enhance high quality employment outcomes, etc.

4. Recommendations/Implications on Research Priorities:
To set research priorities that emphasize grassroots input providing real-world linkage and public policy input.

- To assign responsibility to ICDR for synthesizing the commonalities of competing research studies across funding agencies and support research collaboration between funders.
- Increase the accessibility of the research findings to enhance its utility and applicability.
- Increase research projects that represent a variety of models such as longitudinal, or emphasis on local concerns.
- Place greater value on a research project's utilization plan by establishing criteria for, and awarding significant number of points for this area in the review process.

5. Recommendations/Implications on Development of Research Project Agenda: To develop a research agenda that is: directly applicable to the rehabilitation service delivery system; based upon high quality measurable outcomes; and clearly beneficial to specific audiences including people with disabilities.

6. Recommendations/Implications on Creating a Dissemination and Implementation Plan: To define, as part of the national rehabilitation research agenda, a multifaceted dissemination plan aimed at the utilization of research outcomes by identified audiences including persons with disabilities.

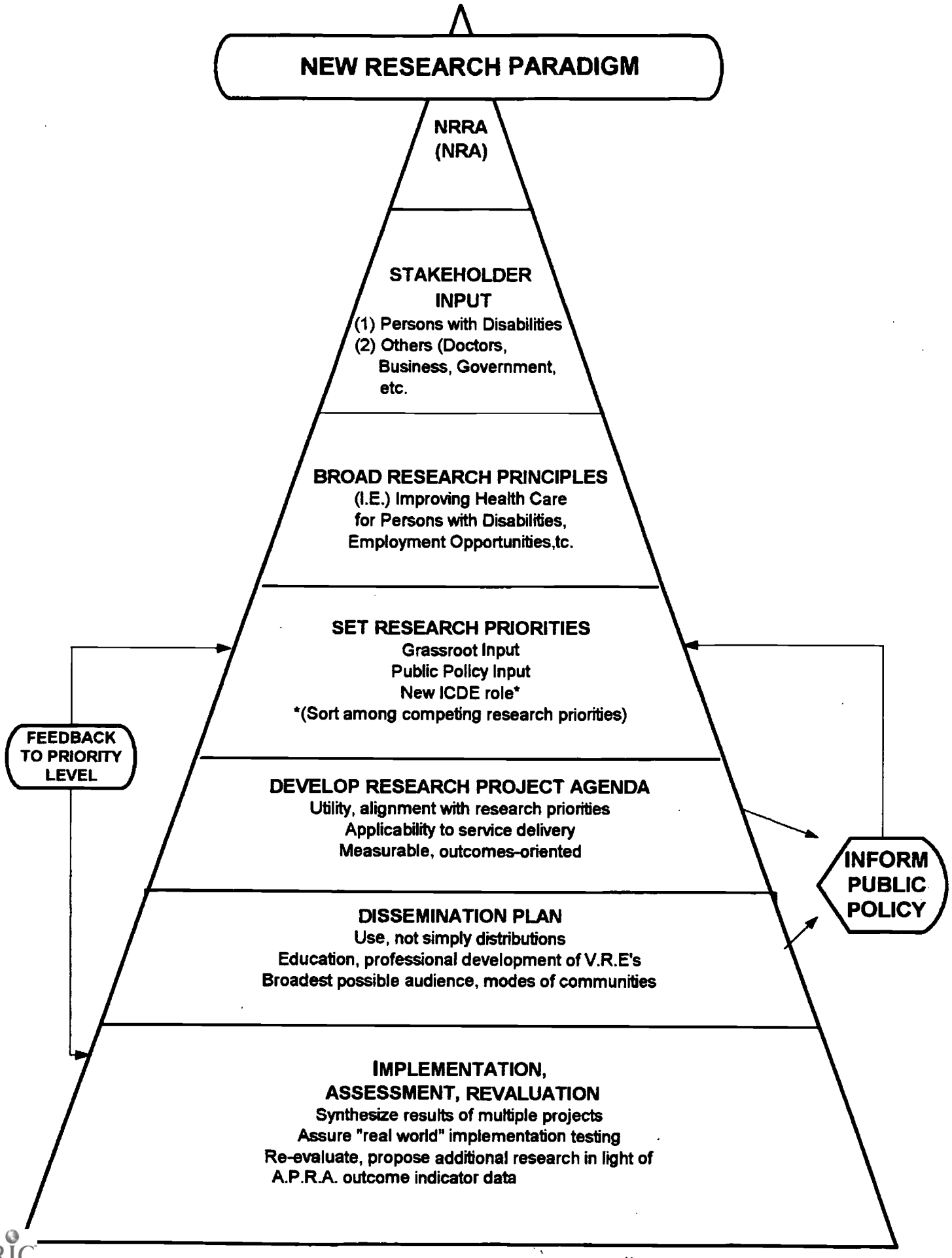
- Dissemination and implementation plans that incorporates a variety of outreach strategies to underserved groups.
- The use of the research findings and not simple dissemination or documentation.
- Insure that standards are based upon research that reflects effectiveness and innovation in the vocational rehabilitation process (e.g. CARF, CRC, etc.).
- Development of broad-based user-friendly archive of current research designed to inform high quality V.R. service delivery.

7. Recommendations/Implications on Implementation, Assessment, and Reevaluation:

- To develop a means for synthesis of the results of multiple research projects that moves it towards more effective utilization by consumers, practitioners, service providers and other stakeholders.
- To assure a real world laboratory approach for researchers to work along side practitioners and consumers to integrate research findings, refine the applications and demonstrate the utility of the research.
- To extend the research process to include a follow along of the research project to assess its utilization plan and the extent to which the anticipated outcomes were achieved.
- To re-evaluate research projects to determine continuation of the research or expansion of the project in relationship to its value added benefits and priority using GPRA (Government Performance and Results Act) Indicators.

*The visual display of these recommendations are reflected in the "New Research Paradigm" model which follows.

Geri Hansen


NEW RESEARCH PARADIGM
NRRA
(NRA)
STAKEHOLDER
INPUT
(1) Persons with Disabilities
(2) Others (Doctors,
Business, Government,
etc.
BROAD RESEARCH PRINCIPLES
(I.E.) Improving Health Care
for Persons with Disabilities,
Employment Opportunities,tc.
SET RESEARCH PRIORITIES
Grassroot Input
Public Policy Input
New ICDE role*
*(Sort among competing research priorities)
FEEDBACK
TO PRIORITY
LEVEL
DEVELOP RESEARCH PROJECT AGENDA
Utility, alignment with research priorities
Applicability to service delivery
Measurable, outcomes-oriented
INFORM
PUBLIC
POLICY
DISSEMINATION PLAN
Use, not simply distributions
Education, professional development of V.R.E's
Broadest possible audience, modes of communities
IMPLEMENTATION,
ASSESSMENT, REVALUATION
Synthesize results of multiple projects
Assure "real world" implementation testing
Re-evaluate, propose additional research in light of
A.P.R.A. outcome indicator data

Bio-models of Diverse Communities

Norman G. DeLisle, Jr.

Until recently, the use of models drawn from the biological sciences has been rightly criticized because of the ideological and political uses that totalitarian regimes and movements made of them. In the last two decades, the development of the ecological sciences and the interest in the relationship between chaos, complexity, and order, have fueled a remarkable renaissance in using conceptual frameworks developed as a result of biological scientific investigation.

Human social groups are becoming closer to one another, both in the physical sense of denser population, and in the informational sense of increased amounts and variety of communications. All living organisms must solve the problem of how to relate to their neighbors, and evolution has created an astounding variety of ways to solve this core problem of living. Typical kinds of relationships include parasitism, symbiosis, predator-prey, federative, infectious, and indirect relationships in ecological systems.

All represent variations of the general relationship of co-evolution. In a co-evolutionary relationship, the act of relating improves the evolution of both parties. Some co-evolutionary relationships are comprised of adaptive challenges, and some of mutual support. Even in parasitism and predator-prey relationships, the species benefits over time from what is an unpleasant, even deadly experience for the prey or the host. On the other end of the continuum is symbiosis, in which dramatically diverse organisms relate to one another in a mutually supportive way. In fact, the current theory of the origin of complex cells is that different organisms gradually chose to federate, and work together for their common survival. Over time, they became so symbiotically integrated that they seemed to us a single organism for a very long time. Nonetheless, these integrated components have maintained their separate genetic structures and separate activities over literally billions of years. A fine model of mutuality and maintenance of core identity, if ever there was one!

Embryogenesis represents a more complex form of the relationship of diversity. In human or mammalian embryonic growth, the core event is the integration of two very unlike living entities, the sperm and the egg. This event causes a generative explosion of diversity, eventually resulting in approximately 250 different kinds of cells. ALL of these cells must relate to one another within significant, if broad, boundaries for a human being to continue to live. This is astounding enough, but the creation of the 250 cell types must maintain the adaption of the organism to its environment at all times during that development. At the very same time that the cells of the fetus are diversifying, they must all cooperate well enough to promote survival of the whole as well as the "self-expression" of individual cell identity in nerve, liver, blood, muscle, and the many other cell variations that occur. This process is as profound a definition of community as one is likely to find, and a source of much potential good if studied for its lessons in the planning and organization of modern communities.

At the ecological level, many different species must constantly relate to one another , not just to maintain their own survival as a species, but the maintenance of the ecology as a whole, upon which each species depends. There are two "strategies" for accomplishing this, exemplified by the rain forest ecologies of Hawaii (an island) and Costa Rica (a land mass embedded in others).

Hawaii was once a pristine ecology, with a remarkable variety of plants and animals, slowly evolving over time, but always maintaining its support environment. With the advent of world travel, Hawaii has begun to experience invasion by species that developed elsewhere, and has been engaged in a struggle for its very ecological survival for a century. The problem is that the ecology of Hawaii developed in isolation, and the only relationships that needed to evolve were those that built relationships between the small number of existing species on the islands. As outside species began to enter this paradise, a weakness of the ecology was exposed-the native species had no resilience.

Resilience is largely a result of the diversity in species experience and the impact of that experience on the genes. In a very real sense, the diversity of experience is translated into a genetic diversity. This genetic diversity is roughly equivalent to resilience. The loss of genetic diversity can occur for many reasons. Isolation is one, over-hunting combined with parasites (Michigan's Lake Trout is sorely lacking in resilience), and human

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choice, as in the homogeneity of the genetics of our plant crops. In each case, long term survival is threatened.

Costa Rican ecology has been subjected to species invasion since its inception. Although the ecology of Costa Rica is every bit as complex and beautiful as that of Hawaii, it is also much more resilient to invasion, thus promoting the survival not only of the tougher individual species, but also the entire ecology. (Of course, it remains to be seen if either ecology can survive the invasion of the human species).

The maintenance of diversity can't be successful in a garden-like environment. We must constantly challenge our communities with the new (weeds) if we expect them to survive. I have always felt that the various disability communities have not learned this lesson especially well. Many think that they can survive best by isolating themselves from the rest of the disability and non-disability world by reducing, even eliminating relationships through superficial communication and separate agendas. It isn't so much that different communities shouldn't have separate agendas, but that we must find a way to marry those agendas into a kind of "issue ecology" to provide us with overall community resilience and avoid the fate of Hawaii.

The creation of complex ecologies is a mystery in itself. We are beginning to have an understanding of how complex order, like an ecology, comes about from the actions of huge numbers of "agents" (organisms or people). It isn't by removing diversity and homogenizing behavior. Rather it is a result of local communication between diverse entities, and adaptation at that local level. The use of local communication and relationships, leading to local adaptation allows more flexible "regions" to develop, which in turn can adapt to one another. Resilience is maintained, and in fact grows, by combining local adaptation with the continuous pursuit of new communication links. This process is referred to as "emergence", and is the subject of much scientific interest now (especially since an understanding of emergence might lead to a better understanding of markets and ecologies). One thing is sure, however. You can't create complexity and stability and novelty through command and control, or homogenization.

A last potentially useful bio-model comes from the study of the unseen potential that resides in the resilient genetic structures of those oldest of living beings, the bacteria. As rehabilitation professionals and members of the human services community, we all have a sense of untapped potential in the persons with whom we work. Often, a key step in successful rehabilitation is building a sense that real potential exists, both in the counselor' mind and the heart of the person using the services. We can look to the oldest of our ancestors for clues as tot he breadth of that potential.

Perhaps the most telling model that can offer a universe of guidance and ideas to us in how to deal with diversity is the response of bacteria to the loss of their normal food source, and its replacement with a substance that has not only never been food for bacteria, but has never existed in any quantity until the last few decades. Note that the bacteria can't reproduce without a useable food source, so none of what follows is a result of "normal" evolution through winning the reproductive race. To summarize a complex response to extraordinary novelty, the bacteria search their active chemical processes (their tool kit of roughly 500 processes, as it were) for reactions that have any effect on the new substance. At this point, the ability of these processes to affect the new substance is so limited that if the reactions were grant proposals, they would never be funded.

The bacteria take the genes of these chemical processes and turns off the very sophisticated genetic repair mechanisms that have developed over the last few billion years. This has the effect of exposing the cell's substance-affecting reactions to very rapid genetic change from radiation and other environmental "toxins". Because there are always many bacteria, and because under normal circumstances, even bacteria of the same species have different genetic resources from one another, the rapid genetic alteration leads to the rapid development of chemical processes that are effective at using the new substance as food. These bacteria preferentially reproduce and soon fill the available space.

There are many lessons in this example, not the least of which is how poorly our own organizations compare with this startling model of flexibility, adaptation, and the use of inherent potential. Perhaps the strongest message is that the preservation of diversity within and among ourselves serves us individually, the communities to which we belong, and the larger social "ecology" of which we are a part, whether we understand that or not.

In the past, we have threatened our communities and, indeed, our species, with annihilation through weapons of mass destruction and our simple belief that we can deal with difference by denying it or exiling it. In the current world, there exist more subtle dangers to our future in the belief that we can hide from the new by protecting the past, that we can benefit by destroying difference through cultural competition, or that those we see as alien are not important to our own survival.

We live and prosper today because our ancestors learned the lessons of preserving, using, and celebrating wide difference. If we do not learn the same lessons, we will simply have no future. Or, perhaps, we will have the future of the Lake Trout of the Great Lakes-a precarious survival in a narrow range of circumstances that we must endlessly pursue because our environment (as all environments in history have) keeps shifting beneath our feet, becoming our enemy.

How much better to embrace diversity, struggle with it, for the best relationships we can with it. We will experience challenges, we will experience real risks, but better a struggle of our own choosing than one imposed on us by our ignorance.

Annotated References

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This is an accessible description of the entire process of embryogenesis, with medical, scientific, spiritual, political, and social associations with each stage of development. Well done, very entertaining.

Holland, J. H., 1998. "Emergence: From Chaos to Order", Reading, MA: Helix Books.

John Holland is a Michigan Professor with a clear and elegant style. He discusses math and logic with a deep understanding, and makes the large scale results of the actions of huge numbers of agents understandable.

Jantsch, E. and Waddington, C.H., eds., 1976. "Evolution and Consciousness: Human Systems in Transition", Reading, MA: Addison-Wesley.

This collection of seminal essays talks about many of the concepts in this paper from the early days of thinking about chaos, emergence, and complexity.

Jantsch, E., 1980. "The Self-Organizing Universe", New York: Pergamon Press.

The first attempt of which I am aware to make the ideas of the so-called, "new sciences" understandable. The book also does a credible job of using these ideas across the many levels of human reality.

Kauffman, S. A., 1993. "The Origins of Order: Self-Organization and Selection in Evolution", New York: Oxford University Press.

A truly profound book. This is THE book if you wish a deep understanding of order, complexity, and chaos. Many of the new ideas of the last few years have been treated with skepticism in many quarters, but no one ever criticizes Kauffman's approach.

Kauffman, S. A., 1995. "At Home in the Universe: The Search for the Laws of Self-Organization and Complexity", New York: Oxford University Press.

The engaging and accessible version of "Origins of Order".

Volk, T., 1998, "Gaia's Body", New York: Copernicus Springer-Verlag.

An intriguing, poetic, yet scientifically grounded view of the meaning of ecology on a planetary scale. An easy and entertaining read.

Wesson, R., 1991. "Beyond Natural Selection", Cambridge, MA: MIT Press

The best critique of traditional Darwinism I've seen, this is the book with the "bacteria learning to eat" story. It also contains absolutely marvelous stories about what life has learned to do. Comprehensive in its critique, as well.

Impact of the Workforce Investment Act on Accountability in the Vocational Rehabilitation Services Program

Harold Kay

Accountability for the State Vocational Rehabilitation (VR) Services program is established primarily in three ways: a) the Government Performance and Results Act (GPRA), b) the VR evaluation standards and performance indicators, and c) VR agency State Plans and program monitoring.

GPRA requires that U.S. Government programs provide annual performance plans that include outcome indicators. Starting in the year 2000, budget requests are to be justified based on program performance as measured by the GPRA indicators. The VR evaluation standards and performance indicators measure performance at the State VR agency level, while the GPRA indicators measure the aggregate performance of all State VR agencies. The VR evaluation standards and performance indicators contain key measures that are very similar to the GPRA indicators.

Each State VR agency submits a State Plan containing assurances and specific information demonstrating compliance with the requirements of section 101 of the Rehabilitation Act. The 1998 Amendments to the Rehabilitation Act revised section 101(a)(15) to require State VR agencies to use the results of a comprehensive statewide assessment of rehabilitation needs and the VR evaluation standards and performance indicators as bases for developing State VR agency goals and priorities. In addition, under section 107(a)(1) of the Act, RSA conducts monitoring to determine whether, in the administration of the State Plan, a State is complying substantially with the provisions of the plan and with the VR evaluation standards and performance indicators. Thus, the VR evaluation standards and performance indicators are considered a crucial part of a comprehensive, integrated system of accountability for the VR program. The focus of this paper is on the evaluation standards and performance indicators and the impact that the passage of the Workforce Investment Act in 1998 had on the standards and indicators.

Background

In the Rehabilitation Act Amendments of 1992, section 106 was added to Part A of Title I. Section 106 required that: a) standards and performance indicators be developed and published for the VR program; b) they must include outcome and related measures of program performance that facilitate and dont impede the accomplishment of the purpose and policy of the program; c) they must be developed with input from State VR agencies, related professional and consumer organizations, recipients of VR services, and other interested parties; d) each State VR agency must report annually on the extent to which it is in compliance with the evaluation standards and performance indicators; e) State VR agencies that perform below the performance levels required in the standards must jointly develop with the Rehabilitation Services Administration (RSA) a program improvement plan outlining specific actions to be taken to improve program performance; f) failure to develop or comply with a program improvement plan can result in financial sanctions; g) RSA will provide a report to Congress containing an analysis of program performance, including relative State performance.

In August, 1998, Congress passed the Workforce Investment Act of 1998 (Workforce Act). The Rehabilitation Act was amend-

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ed and incorporated into Title IV of the Workforce Act. This had significant implications for the VR evaluation standards and performance indicators. The Department of Education has published proposed evaluation standards and performance indicators in a Notice of Proposed Rulemaking (NPRM) in the Federal Register (October 14, 1998, pp. 55291-55305). This paper describes those standards and indicators and focuses specifically on the relationship between the standards and indicators and the core indicators that have been promulgated in the Workforce Act. This paper will also discuss some relevant data collection issues.

Proposed Evaluation Standards and Performance Indicators

Two standards and supporting indicators are proposed for immediate implementation because data currently exist to support them. Three additional standards and appropriate indicators have also been proposed for public comment, but they cannot be implemented at this time because necessary data collections must be developed and implemented. The two standards and relevant indicators currently proposed for implementation appear below.

Note: the standards and indicators are displayed here in a shortened form to facilitate easy reading and do not represent the technically correct language in the NPRM.

Evaluation Standard 1--Employment outcomes.

Performance Indicator 1.1. The number of individuals exiting the VR program who achieved an employment outcome compared to the number of individuals achieved an employment outcome during the previous year.

Performance Indicator 1.2. Of all individuals who exit the VR program after receiving services, the percentage who achieved an employment outcome.

Performance Indicator 1.3. Of all individuals who achieved an employment outcome, the percentage who obtained competitive, self-, or Business Enterprise (BEP) employment and earned at least the minimum wage.

Performance Indicator 1.4. Of all individuals who obtained competitive, self-, or BEP employment with earnings equivalent to at least the minimum wage, the percentage who are individuals with significant disabilities.

Performance Indicator 1.5. The average hourly earnings of all individuals who exit the VR program in competitive, self-, or BEP employment compared to the State's average hourly earnings for all individuals in the State who are employed.

Performance Indicator 1.6. Of all individuals who exit the VR program in competitive, self-, or BEP employment with earnings equivalent to at least the minimum wage, the increase from application to exit in the percentages reporting their own income as their largest single source of economic support.

Performance Indicator 1.7. Of all individuals exiting the VR program in full-time competitive employment, the percentage who can enroll in a medical insurance plan that covers hospitalization and is made available through the individual's place of employment.

Evaluation Standard 2--Equal access to services.

Performance Indicator 2.1. The service rate for all individuals with disabilities from minority backgrounds as a ratio to the service rate for all non-minority individuals with disabilities.

Performance Indicator 2.2. The percentage of individuals with significant disabilities who exit the VR program after receiving services who are minorities as a ratio to the percentage of individuals in the State's working age population reporting a disability that prevents them from working who are minorities.

Standards and indicators proposed for implementation after data collections are developed and implementation appear below.

Draft Proposed Evaluation Standard 3 (Consumer Satisfaction)

Draft Proposed Performance Indicator 3.1: Of all individuals receiving VR services, the percentage who are satisfied with their participation in decision-making in the development and implementation of their Individualized Plan for Employment (IPE).

Draft Proposed Performance Indicator 3.2: Of all individuals receiving services, the percentage who are satisfied with: 1) the appropriateness, timeliness, quality, and extent of the services they received, 2) their interactions with providers of those services, and 3) their interactions with VR counselors and other DSU staff.

Draft Proposed Performance Indicator 3.3: Of all individuals who obtain employment, the percentage who are satisfied with their employment.

Draft Proposed Evaluation Standard 4 (Retention of Employment and Earnings)

Draft Proposed Performance Indicator 4.1: Of all individuals who have achieved a competitive, self-, or BEP employment outcome with earnings equivalent to at least the minimum wage, the percentage who have maintained employment 6 months and 12 months after exiting the VR program.

Draft Proposed Performance Indicator 4.2: Individuals with significant disabilities who have maintained competitive employment, including earnings equivalent to at least the minimum wage, 6 months and 12 months after exiting the VR program as a percentage of all individuals with significant disabilities who achieved a competitive, self-, or BEP employment outcome with earnings equivalent to at least the minimum wage.

Draft Proposed Evaluation Standard 5 (Adequate Use of Resources)

Draft Proposed Performance Indicator 5.1: Of the total amount of all Federal VR and State funds spent in support of activities described in the State Plan, the percentage of Federal VR and

State funds spent on direct services to consumers, including services provided directly by the staff of a DSU.

The Workforce Act and Standards and Indicators

In the Rehabilitation Act Amendments of 1998, section 106 was modified to require that, to the maximum extent practicable, the standards and indicators, described above, be consistent with the core indicators in section 136 of the Workforce Act. Those core indicators generally apply to other programs in the Workforce Act. Those core indicators are:

(I) entry into unsubsidized employment;

(II) retention in unsubsidized employment 6 months after entry into the employment;

(III) earnings received in unsubsidized employment 6 months after entry into the employment; and

(IV) attainment of a recognized credential relating to achievement of educational skills, which may include attainment of a secondary school diploma or its recognized equivalent, or occupational skills, by participants who enter unsubsidized employment, or by participants who are eligible youth age 19 through 21 who enter postsecondary education, advanced training, or unsubsidized employment.

Of the four core indicators, Indicator (IV), attainment of a recognized credential relating to achievement of educational skills.... is not addressed by the VR evaluation standards and performance indicators because the State VR program focuses on employment outcomes, not educational outcomes (see, e.g., sections 100(a)(1)(F) and 102(b)(3)(A) of the Rehabilitation Act). The NPRM invites comments on the appropriateness of including Core Indicator (IV) as a significant measure of success for the State VR program. The other three indicators are quite pertinent to the State VR program. Specifically, the NPRM states that indicators 1.3 (percentage of individuals with employment outcomes who obtain competitive employment, etc.) And 1.4 (percentage of individuals competitively employed who have significant disabilities) support Core Indicator (I) (entry into unsubsidized employment). Proposed Standard 4 (Retention of Employment and Earnings) will support core indicators (II) and (III).

Indicators and Data Collection Issues

The Workforce Acts core indicators are compatible with, and will be supported by, data elements that were utilized in employment activities carried out under the Job Training and Partnership Act by the Department of Labor, and these data elements will provide a basis for Workforce Investment Act program data. RSA data elements, collected on the RSA-911 Case Service Report, do not conform exactly to Labor Department measures, but they are very similar. However, Section 101(a)(10)(B) of the 1998 Rehabilitation Act Amendments states that RSA will require State VR agencies to provide annual reports on individuals receiving VR services on the specific data elements described in section 136(d)(2) of the Workforce Act that are determined to be relevant in assessing the performance of State VR agencies. It also appears that since Section 136(d)(2) refers to all Workforce Investment Act activities, RSA will need to coordinate with the Department of Labor regarding the specific nature of those data collection elements. In the meantime, some RSA-911 data elements are closely related to the data measures that will be required to support the core indicators, and those RSA-911 data elements will be utilized for VR standards and indicators.

Relative to Core Indicator (I), entry into unsubsidized employment, this indicator seems closely related to current RSA-911 data on case closure into competitive employment, self-employment and Business Enterprise (BEP) employment. Thus aspects of Core Indicator (I) can be implemented in the VR evaluation standards and performance indicators.

Relative to Core Indicators (II) and (III), RSA does not currently collect data on individuals who obtain employment six months after entry into employment, but new RSA reporting requirements, when implemented, will change the situation.

New RSA Data Collection Requirements

Section 101(a)(10) of the Rehabilitation Act as amended in 1998 requires that the following data will be collected in the future:

> The number (of VR consumers) who ended their participation in the program and who were employed 6 months and 12 months after securing or regaining employment, or, in the case of individuals whose employment outcome was to retain or advance in employment, who were employed 6 months and 12 months after achieving their employment outcome, including the number who earned the minimum wage rate or another wage level set by the Commissioner, during such employment.

In meeting this requirement, RSA will acquire the basic data needed to support Core Indicators (II) and (III). However, certain data collection issues need to be resolved. First, how will the six and twelve month follow-up data collections be accomplished? Mail or telephone follow-up would provide the information required, but they are expensive and often suffer inadequate response rates. Inadequate response rates can be remedied, but only by escalating costs. Follow-up via electronic means, particularly by using a State's Unemployment Insurance (UI) database, is much less expensive. But, electronic follow-up has other problems including: the data available are not necessarily the data required (e.g. a UI database reports aggregated quarterly earnings, it will not demonstrate that an individual is working precisely six months after entering employment); a State's privacy laws may restrict access to appropriate databases, and the geographical area covered by the database may not include a significant number of employed individuals (e.g., the UI database will not contain records of a State's residents who work out of the State).

Conclusion

As noted above, the evaluation standards and performance indicators are part of a multi-pronged effort to ensure the State VR Services program is accountable. Those standards and indicators will cover a much broader range of performance issues than the

Workforce Act's core indicators. But Core Indicator (I) will be addressed by the VR standards and indicators since entry into employment is a major objective of the State VR Services program, and RSA has data available to measure performance in this area.

RSA does not currently have data to support core indicators (II) and (III), but the new data reporting requirements in Section 101(a)(10) ensure that RSA will obtain the necessary data and utilize those core indicators. However, the data and measurements used by RSA do not conform precisely to those used by the Department of Labor in other Workforce activities, and decisions need to be made regarding how, and to what extent, the RSA-Labor datasets will be synchronized. Finally, decisions need to be made regarding how follow-up will be conducted and used.

Accountability and the 1998 Rehabilitation Act Amendments

Thomas G. Stewart

In order to appropriately comprehend some of the reasoning behind the 1998 Rehabilitation Act Amendments as well as the streams of accountability that follow, it is necessary to recall some recent political history. The accountability, or lack thereof, of both the Congress and the Administration is evident through their actions or their failure to act. It is important to realize that egos and personalities continue to have an immense impact on legislative proceedings today -- which can, at times, re-route a direct line of accountability.

Making no judgements on the current personal political situation of the President, it has to be remembered that President Bill Clinton was initially elected in 1992 along with a majority of Democrats in both the House and the Senate. President Clinton appointed many individuals with disabilities to high Administration positions as well as individuals who are disability sensitive.

The President along with Mrs. Clinton had an ambitious agenda during his first years in office. Among one of his major goals was to institute a national health insurance system and he turned to Mrs. Clinton to head this challenging project. The proposing of virtual universal health care coverage, which was vehemently opposed by the health insurance industry, may have been a major political miscalculation of the Clinton Presidency.

After the Clinton health care proposals were rejected by the American people, Mrs. Clinton became much like Eleanor Roosevelt had been to President Franklin Roosevelt -- a behind the scenes advisor -- who always had the President's ear. It is interesting to note that after the Clinton health care proposal was defeated, Mrs. Clinton made no further bold policy proclamations on her own. It would seem that there was a distinct turn around in the decision making process and accountability in the Clinton White House. It will be necessary to wait for Mrs. Clinton's memoirs to learn what transpired behind the scenes during this time and afterward. However, those events may be eclipsed by today's headlines.

The President had indicated in the 1992 campaign that Vice President Albert Gore, Jr. would have a major role in the Clinton Administration. The President had assigned to the Vice President the job of examining methods to streamline the federal government bureaucracy. When the Vice President reported to the President on his efforts, one of the recommendations was to consolidate federal job training programs funded by the government.

President Clinton campaigned diligently for Democrats running for Congress in the 1994 Congressional election. Despite the President's popularity and his prodigious amount of campaigning, his political party not only lost seats in the off-year Congressional elections, it lost control of both the House of Representatives and the U.S. Senate. The first change in political party control of both Houses of Congress in forty years.

The change in political party leadership would mean many things to the Clinton Administration. Accountability had shifted with the election of the new Congress. It would also mean a dramatic shift in the ideology of both the Senate, but most especially in House of Representatives. In the U.S. House of Representatives the members were elected on a "one-hundred day platform" -- the Contract With America. The proposals contained in the Contract included: a balanced budget / tax limitation amendment to the U.S. Constitution; proposals to provide more incentives for small businesses and for a large capital gains tax cut; a crime bill centering on sentencing and enforcement; a proposal to increase defense spending; a proposal to provide a whole host of promised tax breaks and protections for families; a proposal for the Presidential line-item veto; a term-limit proposal; tort reform proposals and Welfare Reform. Part of the Republican strategy was to eliminate the U.S. Department of Education and the U.S. Department of Energy.

Since the Contract With America called for action on specific legislation within the first one-hundred days of the Congress, all

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other legislative business was stopped in the House of Representatives during this period including vital fiscal legislation.

Newt Gingrich (R-GA), a vocal conservative, was elected Speaker of the House of Representatives. Senator Bob Dole (R-KS) shifted from the role of Minority Leader to that of Majority Leader with a lot more ease. Dole left the position before the Presidential campaign with Senator Trent Lott (R-MS) assuming the role.

New Committee Chairs had been chosen by the new majority party --- Nancy Kassebaum (R-KS) had taken over the Senate Committee on Labor and Human Resources Committee from Senator Edward Kennedy(D-MA). In the House, the Committee changes were even more dramatic -- as a mater of fact, the old House Committee on Education and Labor was renamed as the House Committee on Economic and Educational Opportunities (renamed again in the next Congress to the House Committee on Education and the Workforce) with Congressman William Goodling (R-PA), an avowed conservative, taking the Chairmanship from the liberal Congressman William Ford (D-MI).

With relish, the new House of Representatives tossed out all of the old Congresses baggage, a direct confrontation with the Clinton Administration was unavoidable.

That direct confrontation came in the form of a federal government shut-down because of disagreement on fiscal issues between the Congress and the President.

In the 103rd Congress Senator Nancy Kassebaum, as a minority party member, had introduced a bill to consolidate federal job training programs. Since she was a member of the minority party, the legislation died at the end of the 103rd Congress. However, as new Committee Chair, Senator Kassebaum floated the notion of job consolidation once again. However, in the 104th Congress, Senator Kassebaum's legislation was given much more credence and consideration.

In the House, a bill, the Consolidated and Reformed Education, Employment and Rehabilitation Systems Act (CAREERS), which would have block granted training programs, including the Vocational Rehabilitation program and Vocational Education programs, to the States and would have set up local governing authorities to decide policy was approved the House Committee on Economic and Educational Opportunities.

However, during House Floor consideration, Congressman Gene Green, a first-term Democratic member from Texas, offered an amendment to take Vocational Rehabilitation programs out of the legislation-- and despite a last minute appeal by Speaker Gingrich, the amendment passed. The combined political power of most of the disability community had been realized.

Senator Kassebaum's job consolidation proposal move ahead cautiously after the Green Amendment. When it was finally introduced in the 104th Congress, it included a direct stream of for Vocational Rehabilitation programs. Vocational Rehabilitation programs would have remained under its current structure within Title I of the Rehabilitation Act while being included in the State's planning and implementation of a seamless system of employment training and education programs delivered through one-stop career centers. The Kassebaum bill passed the Senate and was sent to a House / Senate Conference. While a Conference Report was approved by the Conference Committee, the bill was rejected by Democrats. The bill snubbed Democratic concerns by repealing Clinton's 1994 school-to-work law (HR 2884 --PL 103-239) and failing to earmark $1.3 billion for workers laid off because of international competition. Education Secretary Richard Riley and Labor Secretary Robert Reich recommended a presidential veto.

Despite Democratic opposition, Senate Majority Leader Trent Lott (R-MS), promised Kassebaum that he would try and bring the Conference Report to a vote in the waning days of the 104th Congress. Democrats indicated that they would raise a budgetary point of order to defeat the bill. Lott never brought it up for a vote and that version of the issue died at the end of the 104th Congress. Senator Kassebaum had announced her retirement at the end of the 104th Congress. Nonetheless, the groundwork had been laid current for consideration of the 1998 Amendments to the Rehabilitation Act.

Accountability in the 104th Congress came to a head just prior to the National Political Conventions in August 1996. After the government shutdown and a slowdown in the legislative process, Congress went in to high gear and passed major pieces of legislation. The Congress of consternation became a body of conciliation which would carry over into the 105th Congress (1997 1998) and until the President's current personal problems became public.

In 1996, Clinton was re-elected, but voters continued to re-elect a Congress of the opposite political party. While both the House and the Senate remained in Republican hands, the House did so marginally -- by about 21 votes. The Senate actually gained Republican members in the 105th Congress with the Senate divided 55 Republicans to 45 Democrats.

In the House a bill was offered in the House Committee on Education and the Workforce (new name), which was a simple three year Reauthorization of the Rehabilitation Act attached to a job consolidation bill. The House Committee badly needed a "win" after the disastrous defeat and embarrassment of the House leadership by the passage of the Green Amendment. The House passed the bill and it was sent to the Senate for its consideration.

With the retirement of Senator Kassebaum, the Senate leadership chose Senator Jim Jeffords (R-VT), a much more moderate Republican, as Chairman of the Senate Labor and Human Resources Committee. However, Senator Jeffords as a moderate Republican in a body with a conservative Republican majority, had to be extremely cautious with the legislation which was reported from the Senate Committee on Labor and Human Resources to the Senate Floor. The Senate worked on a much more comprehensive Rehabilitation Reauthorization bill, eventually coupled like the House passed legislation, with the job consolidation issue. Unlike the House, the Senate met constantly

through the Rehabilitation Reauthorization process and actually talked with disability organizations about their needs and wants.

A House/Senate Conference Committee was held this year (1998) and unlike the Conference Report on job consolidation of the last Congress, a well crafted compromise bill took shape. The Conference Report was filed in the House of Representatives on July 29, 1998, passed the Senate on July 30, 1998 and passed the House on July 31, 1998. The bill was signed by President Clinton on August 7, 1998 and became Public Law 105-220.

Accountability issues are addressed directly in several areas in the 1998 Amendments:

By consumers who are eligible to receive Vocational Rehabilitation services --

One of the major modifications relates to the implementation of the new statutory requirements for the Individualized Plan for Employment (IPE) as identified in section 102(b) of the Act. The IPE provisions delete some of the former content and process requirements for the Individualized Written Rehabilitation Program (IWRP) and add new provisions to both enhance the collaborative relationships between the eligible individual and the qualified Vocational Rehabilitation counselor with respect to the development, implementation and evaluation of the IPE and to support the exercise of informed choice of the individual in the selection of the IPE's employment outcome, specific services, service providers, and the methods to procure the services.

Accountability in the mediation process --

The Act in section 102(c) now requires States to have procedures both for mediation of and review through an impartial due process hearing of determinations made by personnel of the designated State Vocational Rehabilitation unit that affect the provision of Vocational Rehabilitation services to both applicants and individuals determined eligible for Vocational Rehabilitation services. The Amendments also provide the State the option of establishing procedures for the review of decisions of the impartial hearing officer. If the State chooses to implement this option, the reviewing official can either be the director of the designated State Vocational Rehabilitation agency when there is a designated Vocational Rehabilitation State unit or an official in the Governor's office.

Accountable by the State Rehabilitation Council (Advisory is gone) --

Membership of the Council has been expanded to now include at least one representative of the directors of the projects funded under section 121 of the Act related to the American Indians Vocational Rehabilitation program, if there is one or more of these projects in the State; at least one representative of the State workforce investment board; and at least one representative of the State educational agency responsible for the public education of students with disabilities eligible to receive services under title I of the Act and part B of the Individuals with Disabilities Education Act. The new statutory provision relating to the authority to appoint Council members now reserves this authority solely to the Governor, although for filling Council vacancies, the Governor can delegate this authority to the remaining members of the Council.

While the Council maintains an advisory function to the designated State unit, its functions have been expanded beyond those of an advisory nature as evidenced by the name change introduced by the 1998 Amendments from the State Rehabilitation Advisory Council to the State Rehabilitation Council. Within this context, the Council must in partnership with the State Vocational Rehabilitation unit develop, agree to, and review State goals and priorities consistent with section 101(a)(15)(C) of the Act that must be described in the title I State plan to be submitted to RSA.

Accountability of the State Agency --

Section 101(a)(10) of the Act identifies reporting requirements for the Vocational Rehabilitation program. While some of the data are already being collected and/or reported by State agencies through the various RSA reporting instruments, the Act now identifies some data elements, such as the number of individuals with disabilities and the number with significant disabilities who have maintained employment six and twelve months after achieving, regaining, or advancing in employment, that will require State agencies to determine how best to gather and report these and the other data mandated by the statute. Although reporting mechanisms and instructions will need to be developed by RSA, State agencies need now to examine the mandated data elements to determine the most effective and efficient procedures it will need to develop to gather the data.

The 1998 Amendments to the Rehabilitation Act are clearly a compromise between the House and the Senate with input from the U.S. Department of Education, the disability community and the Vocational Rehabilitation community. The promulgation of regulations to implement these 1998 Rehabilitation Act Amendments as well as the federal job training program consolidation portion of the legislation will take a tremendous amount of cooperation between the U.S. Department of Education and the U.S. Department of Labor. Accountability issues continue to be "uncovered" as the new law (PL 105-220) is read, re-read and interpreted.

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Errata

Page 12
Friends of Mary Switzer
The following names should be added:
Tommy Allen
John Lui
Patricia Owens

Chapter One
Responsibilities of People with Disabilities

Page 23
Second column, third full paragraph, line two:
The word "suspicion" in the text should read suspension.

Page 26
First column, first full paragraph, final sentence should read:
Most of what you think you need in order to be happy, you don't.

Page 26
First column, second full paragraph, third line from the end:
Delete the word thing.

Mary E. Switzer Memorial Seminar and Monograph

To perpetuate the memory of a great woman and great leader in the field of rehabilitation by establishing a memorial that will expand and enrich services to persons with disabilities.

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