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CRCC [Commission on Rehabilitation Counselor Certification] Documents [1975-1981] [2]

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Rehabilitation Counselor Certification

An Update

Within the past five years, the field of rehabilitation counseling has demonstrated a significant concern for professional standards. During this period of time, graduate level training programs united to establish the National Council of Rehabilitation Educators (NCRE) and an independent accreditation commission, the Council on Rehabilitation Education (CORE), was created to establish and monitor minimum standards for rehabilitation counselor education programs. This period also witnessed the development of consumer organizations (e.g., American Coalition of Citizens with Disabilities (ACCD)), concerned with standards of program service delivery, and a growing concern evidenced by RSA for establishing and evaluating standards for State-Federal program performance. In the private sector we have seen the rapid growth of standards for private facilities providing rehabilitation services implemented through the Council for Accreditation of Rehabilitation Facilities (CARF).

One of the most significant developments to occur during this period of time was the development of a voluntary certification program by practicing rehabilitation counselors. The Rehabilitation Counselor Certification program was a direct out-growth of the concerns of practicing rehabilitation counselors to establish a national professional scale of minimum standards for practice which any interested group, agency, or individual could use as a measure.

The primary purpose of certification is to establish professional standards whereby disabled individuals, related professionals, agency administrators, and the general public can evaluate the qualifications of persons practicing rehabilitation counseling. Certification has as its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the client's best interest. Aside from establishing a measure of professional qualifications for the counselor, certification should further the public interest and increase the confidence of other professions and clients. It is very evident that rehabilitation counselors are seriously encouraging a higher level of performance and qualification that will benefit both the public and the profession through their participation in the certification program which is evidenced by the almost 10,000 counselors who have voluntarily met the standards since the inception of the program only four years ago.

It is also evident that concerned groups within the field of rehabilitation see these standards as essential to effective service delivery. The certification movement has had participation from the: National Rehabilitation Counseling Association (NRCA); American Rehabilitation Counseling Association (ARCA); National Rehabilitation Association (NRA); Council of State Administrators of Vocational Rehabilitation (CSAVR); National Association of Non-White Rehabilitation Workers (NANWRW); Association of Rehabilitation Facilities (ARF); American Coalition of Citizens with Disabilities (ACCD); Council on Rehabilitation Education (CORE); and the National Council on Rehabilitation Education (NCRE).

Even though these counselor certification standards have existed for less than four years, they have already been incorporated into the Federal Regulations for Intermediate Health Care Facilities; accreditation standards for private rehabilitation facilities; education standards for graduate rehabilitation education programs; licensing standards for rehabilitation counselors; and employment and/or promotion standards for some agencies and facilities. A bill is also being introduced in Congress this year to amend the Rehabilitation Act to include national standards for rehabilitation counselors.

These standards have been administered by the Commission on Rehabilitation Counselor Certification (CRCC). The Commission consists of five appointees from NRCA, five appointees from ARCA, three appointees from The American Coalition of Citizens with Disabilities, Inc., and one each from the Council on Rehabilitation Education, Council of State Administrators of Vocational Rehabilitation, Association of Rehabilitation Facilities, National Association of Non-White Rehabilitation Workers, and the National Council on Rehabilitation Education.

Rehabilitation Counselor Certification is just four years of age and, as such, is still in the process of development and refinement. As with any new program the Commission has continually reviewed its criteria and process and has progressed through the initial developmental stages. As a result, a number of modifications have occurred. Some of the more recent and significant ones include:

a) Graduates from CORE accredited rehabilitation counselor education programs will be eligible to apply for certification immediately upon graduation if they have met the CORE requirements for number of practicum hours supervised by a certified rehabilitation counselor.

b) In meeting the experience requirements of the Commission, all applications other than those covered in (a) above must demonstrate that a minimum of one year of that experience was under the supervision of a certified rehabilitation counselor.

c) The fee structure has been changed to $35.00 for application and $40.00 for the exam. The total cost of certification for the initial five year period, i.e., $75.00, has not been changed.

d) The Certification Maintenance Program went into effect January 1, 1978. (A summary of this program was included in the ARCA (date) newsletter. For an official copy of the Certification Maintenance Plan write to the Commission at 520 North Michigan Avenue - Suite 1504, Chicago, Illinois 60611, 312/644-4329.)

e) The Certification Maintenance Plan calls for approval of all continuing education to be applied to Maintenance after January 1, 1979. This date has been changed to January 1, 1980. That is, continuing education utilized for certification maintenance will not require prior approval if taken between January 1, 1978 and January 1, 1980. The continuing education should, however, still conform to the guidelines of the Certification Maintenance Plan. All certified counselors will receive further information from the Commission regarding the Certification Maintenance

process via direct mail prior to July 1, 1978.

f) Although no specific changes have yet been determined, the Commission is currently reviewing all aspects of the certification process, including application procedures; examination dates; number and location of exam sites; and administrative services provided through contract to the Commission by PEER, Inc. (Professional, Educational and Evaluation Resources, Inc.). It is anticipated that further procedural modifications within the certification process will occur as a result of this comprehensive review. It is the intent of the Commission to provide the profession with the highest quality certification process within the constraints of resources available, and since the process is still new, periodic adjustments are necessary until the most effective, cost-efficient procedures, which are compatible with the needs of the profession, also are achieved.

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Prepared for CAREERS
Dan McAlees - October 20, 1978

CERTIFICATION OF REHABILITATION COUNSELORS

In this brief overview of the development of a national certification program for rehabilitation counselors I will use a format which should answer the most commonly asked questions regarding this new program. If further information is required, the reader should write directly to the Certification Commission.

How Did the Certification Program Develop and How Is It Organized?

The certification program is a direct outgrowth of the concerns of two professional associations -- The National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association -- to establish standards and, consequently, stabilize the field of rehabilitation counseling and to provide a baseline for future professional growth. These two associations appointed a joint committee on certification which became an independent, incorporated Commission on Rehabilitation Counselor Certification in 1974.

The Commission consists of five appointees from the National Rehabilitation Counseling Association, five appointees from the American Rehabilitation Counseling Association, three appointees from The American Coalition of Citizens with Disabilities, Inc., and one each from the Council on Rehabilitation Education, Council of State Administrator of Vocational Rehabilitation Workers, and the National Council on Rehabilitation Education, Association Rehabilitation Facilities, and the National Association of Non-White Rehabilitation Workers.

Within the past five years, the field of rehabilitation counseling has demonstrated a significant concern for professional standards. During this period of time, graduate level training programs united to establish the National Council of Rehabilitation Educators (NCRE) and an independent accreditation commission, the Council on Rehabilitation Education (CORE), was created to establish and monitor minimum standards for rehabilitation counselor education programs. This period also witnessed the development of consumer organizations (e.g., American Coalition of Citizens with Disabilities (ACCD), concerned with standards of program service delivery, and a growing concern evidenced by RSA for establishing and evaluating standards for State-Federal program performance. In the private sector we have seen the rapid growth of standards for private facilities providing rehabilitation services implemented through the Council for Accreditation of Rehabilitation Facilities (CARF).

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One of the most significant developments to occur during this period of time was the development of a voluntary certification program by practicing rehabilitation counselors. The Rehabilitation Counselor Certification program was a direct out-growth of the concerns of practicing rehabilitation counselors to establish a national professional scale of minimum standards for practice which any interested group, agency, or individual could use as a measure.

These standards include criterion in the areas of education, experience, peer assessment, supervisor assessment, continuing education, acceptance of a code of ethics, as well as an examination which was field based and composed of problem-solving type items designed to be relevent to the day by day decision making processes of the rehabilitation counselor.

What is the Purpose of Certification in Rehabilitation Counseling?

The primary purpose of certification is to establish professional standards whereby disabled individuals, related professionals, agency administrators, and the general public can evaluate the qualifications of persons practicing rehabilitation counseling. Certification has as its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the client's best interest. Aside from establishing a measure of professional qualifications for the counselor, certification should further the public interest and increase the confidence of other professions and clients. It is very evident that rehabilitation counselors are seriously encouraging a higher level of performance and qualification that will benefit both the public and the profession through their participation in the certification program which is evidenced by the almost 10,000 counselors who have voluntarily met the standards since the inception of the program only four years ago.

It is also evident that concerned groups within the field of rehabilitation see these standards as essential to effective service delivery. The Certification movement has had participation from the: National Rehabilitation Counseling Association (NRCA); American Rehabilitation Counseling Association (ARCA); National Rehabilitation Association (NRA); Council of State Administrators of Vocational Rehabilitation (CSAVR); National Association of Non-White Rehabilitation Workers (NANWRW); Association of Rehabilitation Facilities (ARF); American Coalition of Citizens with Disabilities (ACCD); Council on Rehabilitation Education (CORE); and the National Council on Rehabilitation Education (NCRE).

The intent is not to certify that any individual is suitable for employment or attempt to impose personnel requirements upon any agency, but to establish a national professional scale regarding which any interested group, agency, or individual may use as a measure. However, it would be hoped that voluntary cooperation by a majority of rehabilitation counselors would, over time, exercise an increasing influence on the field and ultimately guide legislation, personnel practices, and training programs.

I feel that the singularly most important aspect to true specialization and professionalism is rehabilitation counselor certification. Certification is the process whereby a profession gives recognition to an individual who has fulfilled certain requirements or standards, as pre-determined by that profession.

Aside from establishing a good measure of professionalism for the counselor,

certification will further the public interest. Our most important mission, as rehabilitation counselors, is to better serve the handicapped individuals with whom we work. A counselor who has been certified to have met certain academic knowledge and experience standards by a commission will be more likely to gain public confidence.

This united group of certified counselors is more likely to have a significant voice in community, state, and national affairs than a disbanded group of individuals with little professional stature. Certified counselors can share their common vocational interests, disseminate information relevant to the profession, and seek collectively to gain their common service goals, economically, politically, and socially, on a broad professional level.

Aside from these advantages to the general client population, and the community at large, certification can provide the agency and the counselor himself with definite advantages. It should be noted that the certification process should not be regarded as a screening mechanism, but as a means by which the counselor can assess (and if necessary improve) his skills and competencies, and those of his peers. The counselor who has been certified has the assurance from his profession of its confidence in him. He gains a sense of self-esteem and professional identity. He is worthy of the respect of his peers, members of other professional groups, and of his clients. The fact that he is deserving of the same stature as other professionals within the field of counseling engenders, not only mutual respect, but more harmonious working relationships. With this increase in stature, the rehabilitation counselor can join the human service problem solving team on an equal level without having to compromise his position to medicine, social work, or pyschology. His own special area of expertise will be equally as valuable as the others in providing client services.

Our foremost goal in rehabilitation counseling is to serve the public interest through the provision of quality services to our handicapped population. It would be unconscionable for the members of our profession not to accept their public accountability in assuring the quality of counselors and services provided by individuals with the title "rehabilitation counselor." We felt that rehabilitation counselor certification was inevitable. We are fortunate to have had the opportunity to draw up our own process rather than having this carried out by a lay group. In the long term, counselor certification will have an over-all positive effect upon counselor performance, professional satisfaction, and quality of services.

There are other very valuable outcomes of a certification program. For example: (1) It's impact on education, both pre-service and in-service. In the area of pre-service, it can encourage curriculum modification - encourage refinements of the standards for internship supervision - encourage the upgrading of faculty knowledges in the area of rehabilitation counseling as has already been evidenced by the large number of university faculty who have become CRC's - and finally, by having it's standards incorporated into the accreditation criteria established by the Counsel on Rehabilitation Education. In the area of in-service, it can create demand for relevant and quality training. As more of this training becomes available,it will provide easier access for individual counselors to in-service training and will provide impetus to revision of in-service training delivery systems as sponsored by such groups as Regional Continuing Education

Programs, State Agencies, National Rehabilitation Counseling Association, American Rehabilitation Counseling Association, etc. Data collected by the Commission to date indicates that experienced rehabilitation counselors feel that less than 50% of the in-service training they received was valuable to them in improving their skills to do the tasks assigned. Perhaps the certification movement can make a contribution to improvement in this area. (2) Certification and certification maintenance can encourage the individual counselor, educator, supervisor, and other rehabilitation professionals to continually upgrade their knowledge and skills in the area of rehabilitation counseling. (3) Certification can assist in better defining the practice and profession of rehabilitation counseling through (a) assisting in defining rehabilitation work settings more precisely; (b) by more precisely defining knowledges and skills needed; (c) by more precisely defining the standards necessary for practice. Certification movement can begin to give a clearer answer to the questions of "who is the rehabilitation counselor and where do they practice." Before certification the rehabilitation counselor was anyone hired to do rehabilitation counseling. Now certain standards exist to better define the profession of rehabilitation counseling. (4) Certification has created dialogue regarding the necessary educational and experiential components for rehabilitation counselors between groups of counselors, educators, administrators, and consumers. We have had a great deal of dialogue between these groups regarding such issues in the last few years and it is continuing at a very active pace - that's good for the profession. (5) Certification can assist agencies in maintaining the identity and integrity of rehabilitation. For example, the problems in the recent past are familiar regarding the implementation of the SRS concept, the Florida issue, RSA discontinuing funding of graduate rehabilitation education programs, state laws regarding rehabilitation counselors being supervised by MSW's, etc. Certification of the rehabilitation counseling profession should be able to assist administrators, educators, and other professionals in better dealing with these types of political issues. (6) Certification can assist in establishing guidelines for state licensure bills. For example, the American Personnel and Guidance Association Model Omnibus Bill does not recognize rehabilitation counseling as a unique professional practice area. Certification establishes a national scale of standards that can be utilized by the states in developing individual licensure bills so that we may avoid, in the rehabilitation profession, the establishment of 52 separate scales of standards with all of the problems that this involves.

Even though the counselor certification standards have existed for less than four years, they have already been incorporated into the Federal Regulations for Intermediate Healthcare Facilities, accreditation standards for private rehabilitation facilities, education standards for graduate rehabilitation education programs, licensing standards for rehabilitation counselors, and employment and/or promotion standards for some agencies and facilities. A bill has been introduced in congress this year to amend the rehabilitation act to include national standards for rehabilitation counselors as well.

How is Certification of a Rehabilitation Counselor Maintained?

In 1974, the Commission on Rehabilitation Counselor Certification (CRCC) endorsed the principle of certification maintenance for rehabilitation counselors. The stated objectives of the certification-maintenance process, formally set in motion in January 1978, are to encourage certified rehabilitation counselors to participate in continuing-education activities in which they will be provided with new in-

formation, explore new knowledge in a specific content area, master new skills and techniques, expand approaches toward the management of clients, and develop critical inquiry and balanced professional judgement (Proposed plan for Certification Maintenance developed by the Certification Maintenance Committee of the Commission on Rehabilitation Counselor Certification, in August 1977 and approved September 1977).

The certification-maintenance process requires certified rehabilitation counselors (CRCs) to accrue 150 contact hours during a five-year period (a contact hour is equivalent to a clock hour spent in an approved program). Should CRCs be unable to meet the certification-maintenance requirements through continuing education, they may take the certification examination during the year before their certification deadline. Failure to maintain certification means that a counselor will not be listed in the Registry of Certified Rehabilitation Counselors and may no longer exercise the rights and privileges granted a certified rehabilitation counselor.

The assumption behind certification maintenance is that continuing-education programs are available in sufficient number and at reasonable or no cost for CRCs to meet the requirements for certification maintenance through such programs without personal hardship. The potential sources suggested by the CRCC for such continuing-education are Regional Rehabilitation Continuing-Education Programs (RRCEPs), agency in-service education programs, rehabilitation research and training centers, rehabilitation counselor-education programs, other college and university courses, and professional association-approved courses. There are 11 knowledge and skill content areas in which the CRCC has determined that continuing-education contact hours must be accrued. These areas are rehabilitation philosophy, history, structure, and legislation; medical aspects of handicapping conditions; occupational information and the world of work; counseling theory and techniques; communication organization and resources; placement processes and job development; psychology of personal and vocational adjustment; evaluation and assessment; ability to use research findings and professional publications; and the delivery of rehabilitation services.

The commission has also outlined a quality-approval process to be monitored by CRCC and implemented by member organizations. Member organizations now have until January 1980 to develop and submit alternate plans if they feel that other forms of continuing-education or ways to demonstrate that counselors have maintained their competence in serving clients should be included in this approval process.

Who is Eligible To Be Certified as a Rehabilitation Counselor?

To be eligible for certification, a candidate must meet one of the following requirements of education and work experience:

- Master's degree in Rehabilitation Counseling from a CORE accredited rehabilitation counseling education program with an internship supervised by a CRC: or. . .
- A Master's degree in Rehabilitation Counseling from a non-accredited rehabilitation counselor training program, with a supervised internship, plus one year of acceptable experience under the supervision of a Certified Rehabilitation Counselor: or. . .

- A Master's degree in Rehabilitation Counseling without a supervised internship, or in a related area such as, a Master's degree in a related area (such relatedness to be determined by CRCC on the basis of the candidate's transcript), plus two years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor: or. . .
- A Master's degree in an unrelated area plus five years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor: or. . .
- A Bachelor's degree in an unrelated area plus five years of acceptable experience, at least one of which must have been under the supervision of a Certified Rehabilitation Counselor: or. . .
- A Bachelor's degree in any other area plus five years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor.

How Does the Commission Define "Acceptable Experience in Rehabilitation Counseling"?

Employment acceptable to the Commission for a rehabilitation counselor should include:

1. Techniques of counseling special populations and groups.
2. Vocational exploration.
3. Psychological and vocational assessment.
4. Use of social, medical, vocational, physchiatric information.
5. Job placement and/or job development.
6. Rehabilitation methods in an agency, public or private, business or industry, hospital or clinic, in which the applicant is under professional supervision and has employed such methods and measures.

In order for employment experience to be considered acceptable by the Commission, the candidate's job description must contain the first experience component listed above and at least two of the other experience components listed. Experience gained prior to the granting of the Master's degree or Bachelor's degree will be considered only if it has been under the supervision of a Certified Rehabilitation Counselor. Supervision is defined as a systematic and periodic evaluation of the quality of delivery services.

What is the Certification Examination Like and How Was it Developed?

An intensive field testing process, which spanned a two year period and involved over 8,000 rehabilitation counselors, educators and administrators has resulted in a pool of examination items statistically validated across levels of education, experience, geography and professional functions and level. Since rehabilitation counseling is a dynamic and constantly evolving profession, the Commission maintains a Task Force of rehabilitation counseling professionals who continually add to and upgrade this examination item pool.

Each 300 item multiple choice Certification Examination is drawn from this item pool. Items are practice based and put a higher premium on the application of knowledge in serving clients than on isolated bits of factual information. In scoring the examination, maximum credit is given for the "best response" as determined by the item authors and verified by the field testing process.

What Are the Content Areas Tested by the Certification Examination?

To qualify for certification, the candidate is required to demonstrate competence in the following content areas by achieving a minimum passing score on the Certification Examination as a whole:

1. Rehabilitation philosophy, history, structure and laws.
2. Medical aspects of disability.
3. Psychological aspects of the handicapping condition.
4. Occupational information and the world of work.
5. Counseling theory and techniques.
6. Community organization and resources.
7. Placement processes and job development.
8. Psychology of personal and vocational adjustment.
9. Evaluation and assessment.
10. Ability to utilize research findings and professional publications.
11. The delivery of rehabilitation services.

What Does Certification Cost?

$35.00	Non-refundable processing fee which must be submitted with the Application for Certification
$40.00	Examination and certification fee, due when applicant is approved for participation of the Certification Examination.
$75.00	Total Certification Fee

Where Can One Get Additional Information on Rehabilitation Counselor Certification?

All inquires regarding certification should be directed to the Commission on Rehabilitation Counselor Certification, Suite 3301, 8 South Michigan Avenue, Chicago, Illinois 60611. Phone (312) 236-4499.

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION
520 North Michigan Avenue - Suite 1504
Chicago, Illinois 60611

APPLICATION FOR CERTIFICATION

Instructions for completing this application are contained in the current *Rehabilitation Counselor Certification: Instructions For Applying*. Please refer to those instructions before proceeding and follow them carefully. If your application is incomplete or any of the required verification is missing, your application will be returned to you.

1. NAME: _____ (Last)
_____ (First) (Middle Initial)

Do Not Write In This Space

2. ADDRESS: _____ (Number and Street)
_____ (City, State, and Zip Code)

Home Telephone ( ) _____
Office Telephone ( ) _____

3. SEX (optional)
1. ☐ Male
2. ☐ Female

4. DATE OF BIRTH
Month | Day | 19 Year

5. SOCIAL SECURITY NUMBER

6. SELF-DESCRIPTION (Optional)
1 ☐ American Indian
2 ☐ Asian-American
3 ☐ Black/Afro-Amer
4 ☐ Caucasian
5 ☐ Chicano/Mexican-American
6 ☐ Puerto Rican/Puerto Rican-Amer
7 ☐ Spanish American
8 ☐ Other _____

7. Because of physical limitations (blindness, disability) special arrangements will be necessary for me to complete the Certification Examination; if yes, please explain arrangements that you will need on separate page and attach to application. Yes_____ No_____

8. I prefer to be examined in English. Yes _____ No _____
I prefer to be examined in Spanish. Yes _____ No _____

9. I have previously applied to this Commission for certification as a rehabilitation counselor: Yes _____ No _____
If yes, give previous identification number. _____

10. Earned Degrees:

	Degree	Major	Institution	Date Degree Awarded
Undergraduate				
Graduate				

Did you graduate from accredited Rehabilitation Counselor Education Program? Yes_____ No_____

11. Supervised internship:

Name of Site: _____ Supervisor: _____

Dates: _____ Total Number of Supervised Hours: _____

Site Address (city/state) _____

12. Experience Under the Supervision of a Certified Rehabilitation Counselor:
(Account for a minimum of one year)

A. Name of CRC Supervisor _____

A. Dates under CRC Supervision _____

Place of your employment when supervised _____

Address _____

B. Name of CRC Supervisor _____

B. Dates under CRC Supervision _____

Place of your employment when supervised _____

Address _____

HISTORY OF PROFESSIONAL EXPERIENCE

(Please list most current experience first)

1. Employer: _____

Address: _____

Name of Supervisor: _____ Title: _____

Dates of Employment: From _____ (Month/Day/Year) to _____ (Month/Day/Year) Total Number of Months _____

Job Title: _____

Detailed Description of Duties: _____

_____

_____

_____

_____

_____

_____

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_____

2. Employer: _____

Address: _____

Name of Supervisor: _____ Title: _____

Dates of Employment: From _____ (Month/Day/Year) to _____ (Month/Day/Year) Total Number of Months _____

Job Title: _____

Detailed Description of Duties: _____

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Some commonly asked questions about Rehabilitation Counselor Certification...

WHAT IS THE PURPOSE OF CERTIFICATION IN REHABILITATION COUNSELING?

The primary purpose of certification is to establish professional standards whereby disabled individuals, related professionals, agency administrators and general public can evaluate the qualifications of persons practicing rehabilitation counseling. Certification has its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the client's best interest.

HOW DID THE CERTIFICATION PROGRAM DEVELOP AND HOW IS IT ORGANIZED?

The certification program is a direct outgrowth of the concerns of two professional associations -- The National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association -- to establish standards and consequently stabilize the field of rehabilitation counseling and to provide a baseline for future professional growth. These two associations appointed a joint committee on certification which became an indpendent incorporated Commission on Rehabilitation Counselor Certification.

The Commission consists of five appointees from NRCA, five appointees from ARCA, three appointees from The American Coalition of Citizens with Disabilities, Inc., and one each from the Council on Rehabilitation Education, Council of State Administrators of Vocational Rehabilitation, Association of Rehabilitation Facilities, National Association of Non-White Rehabilitation Workers, and the National Council on Rehabilitation Education.

WHO IS ELIGIBLE TO TAKE THE CERTIFICATION EXAMINATION?

To be eligible for the Certification Examination, a candidate must meet one of the following requirements of education and work experience:

- Master's degree in rehabilitation counseling from an accredited rehabilitation counseling education program will not be required to meet a minimum experience requirement. See attached list for accredited schools.

- A Master's degree in Rehabilitation Counseling from a rehabilitation counselor training program, with a supervised internship, plus one year of acceptable experience under the supervision of a Certified Rehabilitation Counselor: or...

- A Master's degree in Rehabilitation Counseling without a supervised internship, or in a related area such as, A Master's degree in a related area (such relatedness to be determined by CRCC on the basis of the candidate's transcript), plus two years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor: or...

- A Master's degree in an unrelated area plus five years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor: or...

- A Bachelor's degree in Rehabilitation plus four years of acceptable experience, at least one of which must have been under the supervision of a Certified Rehabilitation Counselor: or...

- A Bachelor's degree in any other area plus five years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor.

HOW DOES THE COMMISSION DEFINE "ACCEPTABLE EXPERIENCE IN REHABILITATION COUNSELING"?

Employment acceptable to the Commission for a rehabilitation counselor should include:

1. Techniques of counseling special populations and groups;
2. Vocational exploration;
3. Psychological and vocational asessment;
4. Use of social, medical, vocational, physchiatric information;
5. Job placement and/or job development;
6. Rehabilitation methods in an agency, public or private, business or industry, hospital or clinic, in which the applicant is under professional supervision and has employed such methods and measures.

In order for employment experience to be considered acceptable by the Commission, the candidate's job description must contain the first experience componet listed above and at least two of the other experience componets listed. Experience gained prior to the granting of the Master's degree or Bachelor's degree will be considered only if it has been under the supervision of a Certified Rehabilitation Counselor. Supervision is defined as a systematic and periodic evaluation of the quality of delivery services.

WHAT IS THE CERTIFICATION EXAMINATION LIKE AND HOW WAS IT DEVELOPED?

An intensive field testing process, which spanned a two year period and involved over 8,000 rehabilitation counselors, educators and administrators has resulted in a pool of examination items statistically validated across levels of education, experience, geography and professional functions and level. Since rehabilitation counseling is a dynamic and constantly evolving profession, the Commission maintains a Task Force of rehabilitation counseling professionals who continually add to and upgrade this examination item pool.

Each 300 item multiple choice Certification Examination is drawn from this item pool. Items are practice based and put a higher premium on the application of knowledge in serving clients than on isolated bits of factual information. In scoring the examination, maximum credit is given for the "best response" as determined by the item authors and verified by the field testing process; however, credit may also be given for other responses which may be useful approaches to the problem at hand.

WHAT ARE THE CONTENT AREAS TESTED BY THE CERTIFICATION EXAMINATION?

To qaulify for certification, the candidate is required to demonstrate competence in the following content areas by achieving a minimum passing score on the Certification Examination as a whole:

1. Rehabilitation philosophy, history, structure and laws.
2. Medical aspects of disability.
3. Psychological aspects of the handicapping condition.
4. Occupational information and the world of work.
5. Counseling theory and techniques.
6. Community organization and resources.
7. Placement processes and job development.
8. Psychology of personal and vocational adjustment.
9. Evaluation and assessment.
10. Ability to utilize research findings and professional publications.
11. The delivery of rehabilitation services.

WHAT DOES CERTIFICATION COST?

$25.00 Non-refundable processing fee which must be submitted with the Application for Certification.
$50.00 Examination and certfication fee, due when applicant is approved for partcipation of the Certification Examination.

$75.00 Total Certification Fee

WHERE AND WHEN IS THE CERTIFICATION EXAMINATION ADMINISTERED?

The Certification Examination, as presently structured, is given twice a year, in the Spring and in the Fall. Barrier-free examination sites are set up for each administration according to the geographical mix of approved candidates, to minimize travel expenses for counselors insofar as possible. If a candidate cannot take the examination under ordinary conditions, because of physical limitations or if a candidate wishes to take the examination in Spanish rather than English, special arrangements may be made through the Adminstrative Office.

WHAT WILL BE THE EFFECTS OF CERTIFICATION ON REHABILITATION COUNSELING A A PROFESSION?

It is not the Commission's intent to certify that any individual is suitable for employment or to impose personnel requirements upon any agency. Rather, the intent is to establish a national professional scale which any interested group, agency or individual may use as a measure. It is hoped that participation by rehabilitation counselors would exercise an increasing influence on the field and ultimately guide legislation, personnel practices, and training programs. Aside from establishing a good measure of professional qualifications for the counselor, certification will further the public interest and the confidence of other professions and clients. It is evident to date that rehabilitation counselors are encouraging, through their participation in the certification program, a higher level of performance and qualification that will benefit both the public and the profession.

HOW DOES ONE APPLY FOR CERTIFICATION?

All inquiries regarding certification and requests for application forms should be directed to the Commission on Rehabilitation Counselor Certification, Suite 1504, 520 North Michigan Avenue, Chicago Illinois 60611. Our telephone number is: (312) 544-4329.

Revised - September 1977

REHABILITATION COUNSELOR CERTIFICATION/INSTRUCTIONS FOR APPLYING

Please read these instructions before completing the Application for Certification. If your application is incomplete or any of the required verification is missing, the Application for Certification will be returned to you.

A. *GENERAL INFORMATION*

STANDARDS AND CRITERIA

The Standards and Criteria for Certification are listed in "Some Commonly Asked Questions about Rehabilitation Counselor Certification..." The basic requirements for education and experience must be met before the date of application. Any application will be rejected if submitted before the applicant has met the requirements, and a new application and application processing fee will be necessary for reapplication after the basic requirements are met.

DEADLINES

Education and experience requirements must be met and applications received by February 1, 1978 for the Certification Examination scheduled for administration on April 28, 1978. Applications received after February 1, 1978 will be considered for the October 28, 1978 Certification Examiniation. Note: The Commission cannot be responsible for delays in the postal service!

FEES

A non-refundable $25.00 application processing fee must accompany the Application for Certification. A $50.00 Examiniation and Certification Fee will be required prior to administration of the Certification Examination scheduled for April 28, 1978. The Examination and Certificate Fee will be refunded to applicants unable to sit for the Examination if they notify the Administrative Office prior to April 20, 1978. One defferal from the scheduled examination date is allowed per application. Applicants who defer participation until the Fall 1978 examination and subsequently are unable to sit for that examination will be required to submit a new Application for Certification and the processing fee.

REFERENCES

Professional references are required at a later time in the application process. On receipt of a completed Application for Certification, the applicant is assigned a candidate number and supplied with appropriate reference forms. References will be required from one supervisor and two peers. It is the responsibility of the applicant to ensure that these forms are distributed and returned to the Commission.

STATUS

When all reference forms, transcripts, and required verification have been received, the application will be reviewed as to whether the applicant has met the Standards and Criteria established by the Commission. If approved for participation in the Examination scheduled for administration on April 28, 1978, the candidate for certification will be sent an Orientation Guide for use in preparing for the examination.

B. *COMPLETING THE APPLICATION FOR CERTIFICATION, PAGE ONE*

The numbered instructions below follow the item numbers of the form. NOTE: Applications must be typewritten or printed in ink. If illegible, the Application for Certification will be returned.

1. Print your name as you want it to appear on your Certificate and in the Registry of Certified Rehabilitation Counselors.

2. Print the address you wish published in the Registry of Certified Rehabilitation Counselors. Telephone numbers are for Commission information only.

3. Please note that indication of sex and self-description are optional. Your application will not be considered incomplete should you prefer not to supply this information.

7. Please indicate the nature of disability and what special arrangements, if any, would be necessary to accomodate you at the testing site.

8. The Certification Examination is available only in English and Spanish.

9. Check "Yes" only if you have applied previously and been assigned and identification number. If you check "Yes", please supply the identification number.

10. In order to varify your educational background, the Commission must receive an official transcript which indicates the granting of the Bachelor's or Master's degree you cite as meeting the Education requirements for Certification. The transcript will be considered official only if it bears the seal of the University and signature of the Registrar. If the institution will not release official transcripts to students, the transcripts should be sent directly to the Commission. Your application will be accepted without this official transcript; however, the transcript must be received for approval to participate in the examination.

Please see the attached list to determine which Rehabilitation Counselor Programs are accredited. Note: Your degree must have been received after the program received its accredidation, not before accredidation was granted. Please check the dates listed on the attached list to determine when your program became accredited.

APPLICATION FOR CERTIFICATION, PAGES 2 and 3: PROFESSIONAL EXPERIENCE.

Please note carefully the definition of acceptable experience in rehabilitation counseling as stated in "Some Commonly Asked Questions. . ." Should you feel that more information is needed than can be supplied on the application form, please attach job descriptions or a letter of explanation.

A letter from each employer verifying job title, dates of employment, and brief description of job duties must be submitted with the Application for Certification. Employer verification must be submitted for all employment experiences you cite as meeting the requirements of the Commission. It is your responsibility to contact previous employers for this verification. Letters should not be submitted directly to the Commission.

APPLICATION FOR CERTIFICATION, PAGE 4: STATEMENT OF UNDERSTANDING

Signing the Certification Application carries with it the acknowledgement that the information contained therein is accurate. If, at a later date, the Commission learns that any Certificate was granted on the basis of false or inaccurate information, the Commission reserves the right to suspend or revoke that Certificate.

In addition, signing the Certification Application attests that the candidate subscribes to the Code of Ethics of the Commission on Rehabilitation Counselor Certification as printed on the Application for Certification. The Commission reserves the right to suspend or revoke Certification upon evidence of a violation of this Code of Ethics.

C. CHECKLIST: Before submitting the Application, check and be sure you have:

____ completed all parts of the Application for Certification.

____ signed the application form.

____ enclosed the non-refundable $25.00 application processing fee.

____ enclosed employer verification letters for all experience cited as meeting the requirements.

____ enclosed official transcript or requested institution to send transcript to the Commission.

____ distributed the Certified Rehabilitation Counselor Supervisor Rating Form.

REVISIONS FOR 1978

MOST COMMONLY ASKED QUESTIONS

HOW TO BECOME ELIGIBLE IF I DO NOT HAVE EXPERIENCE UNDER A CRC SUPERVISIOR?

It would be necessary to submit a plan to the Credentials Committee outlining your method for aquireing one year of supervision under a CRC in your geographical area. Supervision is defined as a systematic and periodic evaluation of the quality of delivery services. Meeting all education and experience requirements you may sit under "Provisional Certification".

WHERE AND WHEN IS THE CERTIFICATION EXAMINATION ADMINISTERED?

The Certification Examination is given twice a year, April 28, 1978 and October 28, 1978. The examination will be administrated in each of the ten HEW Regions per year. A special administration will be considered with 20 or more applicants in a given geographical area.

INSTRUCTIONS FOR APPLYING

10.-11. In order to verify your educational background, the Commission must receive an official transcript which indicates the granting of the Bachelor's or Master's degree you cite as meeting the education requirements for Certification. The transcript will be considered official only if it bears the seal of the University and signature of the Registrar. If the institution will not release official transcripts to students, the transcripts should be sent directly to the Commission. Your application will be accepted without this official transcript; however, the transcript must be received before your application is reviewed for approval to participate in the Examination.

NOTE: A gradate from an accredited Rehabilitation Counselor program will not be required to meet the one year CRC supervised requirement. (See Attached List).

12. An applicant's professional experience must include at least one year of acceptable experience under the supervision of a Certified Rehabilitation Counselor. It is the responsibility of the candidate to ensure that the Certified Rehabilitation Counselor Supervisor Rating Form is given to the CRC supervisor for submission to the Commission. Should additional rating forms be required, please photocopy the form provided.

ACCREDITED MASTER'S DEGREE PROGRAMS IN REHABILITATION COUNSELOR EDUCATION

Accredited for 1977-78 by the Council on Rehabilitation Education

UNIVERSITY OF ALABAMA ACC-1975

Doral N. West, Ph.D.
Professor and Chairman
Rehabilitation Counselor Education
University of Alabama 35486

UNIVERSITY OF ARIZONA

Dr. Marsden B. Stokes ACC-1975
Associate Dean and Director
The Rehabilitation Center
College of Education
Tuscon, Arizona 85721

ARKANSAS STATE UNIVERSITY ACC-1976

C. L. McLarty, Ed.D.
Coordinator
Rehabilitation Counselor
Training Program
College of Education
Box 898
Arkansas State University 72467

ASSUMPTION COLLEGE* ACC-1976
(*two year master's program
with internship is only portion
accredited)

Dr. George S. Elias
Coordinator
Institute for Social and
Rehabilitation Services
500 Salisbury Street
Worcester, Massachusetts 01609

AUBURN UNIVERSITY ACC-1976

Conrad M. Allen, Ph.D.
Coordinator
Rehabilitation Counseling
Training Program
School of Education
Room 2054 Haley Center
Auburn, Alabama 36830

CALIFORNIA STATE UNIVERSITY/FRESNO ACC-1976

Joseph L. Townsend, Ed.D.
Coordinator
Rehabilitation Counseling
Training Program
Division of Allied Health Professions
Fresno, California 93710

CALIFORNIA STATE UNIVERSITY/SAN DIEGO ACC-1976

Fred R. McFarlane, Ph.D.
Director
Rehabilitation Counseling Program
School of Education
5402 College Avenue
San Diego, California 92115

SAN FRANCISCO STATE UNIVERSITY ACC-1976

William Evraiff, Ed.D
Chairman
Counseling Department
1600 Holloway Avenue
San Francisco, California 94132

EAST CAROLINA UNIVERSITY ACC-1975

Sheldon C. Downes, Ed.D.
Coordinator
Rehabilitation Counselor Training Program
School of Allied Health and Social Professions
Post Office Box 3248
Greenville, North Carolina 27834

FLORIDA STATE UNIVERSITY ACC-1975

Michael J. Gimmestad, Ph.D.
Acting Director
Rehabilitation Counselor Education
College of Education
902 West Park Avenue
Tallahassee, Florida 32306

UNIVERSITY OF FLORIDA ACC-1975

Jerold D. Bozarth, Ph.D
Professor and Chairperson
Department of Rehabilitation Counseling
College of Health Related Professions
Post Office Box 756
Gainesville, Florida 32610

UNIVERSITY OF GEORGIA** ACC-1976
(**vocational evaluation tract is
not accredited)

Timothy F. Field, Ph.D.
Rehabilitation Counselor Education
College of Education
Athens, Georgia 30601

ILLINOIS INSTITUTE OF TECHNOLOGY ACC-1976

Glen O. Geist, Ph.D.
Associate Professor and Director
Rehabilitation Counselor Education
Lewis College of Sciences and Letters
3300 South Federal Street
Chicago, Illinois 60616

EMPORIA KANSAS STATE COLLEGE ACC-1976

Dr. Marvin D. Kuehn
Director
Rehabilitation Counselor Education
1200 Commercial Street
Emporia, Kansas 66801

MEMPHIS STATE UNIVERSITY ACC-1975

Dr. William Jenkins
Coordinator
Rehabilitation Counselor Education Program
Southern Avenue
Memphis, Tennessee 38111

MICHIGAN STATE UNIVERSITY ACC-1976

Gregory A. Miller, Ph.D
Professor
Rehabilitation Counselor Education
431 Erickson Hall
East Lansing, Michigan 48824

MISSISSIPPI STATE UNIVERSITY* ACC-1976
(*two year master's program with internship is the only portion accredited)

William H. Graves, Ed.D.
Department of Guidance Education
Rehabilitation Counselor Education
College of Education
Post Office Drawer G.E.
Mississippi State University 39762

UNIVERSITY OF MISSOURI AT COLUMBIA ACC-1976

Dr. Richard W. Thoreson
Director, Graduate Training Program
Rehabilitation Counselor Education
College of Education
307 Parker Hall
Columbia, Missouri 65201

NEW YORK UNIVERSITY ACC-1976

Dr. Patricia Dvonch
Coordinator
Rehabilitation Counseling Education Program
School of Education, Health, Nursing and
Arts Professions
Washington Square
New York, New York 10003

UNIVERSITY OF NORTHERN COLORADO ACC-1976

Richard R. Wolfe, Ph.D.
Professor and Chairman
Department of Social Services
and Rehabilitation Services
College of Education
Greeley, Colorado 80631

OKLAHOMA STATE UNIVERSITY ACC-1975

Clayton A. Morgan, Ed.D.
Coordinator
Rehabilitation Counselor Education
College of Education
Stillwater, Oklahoma 74074

THE PENNSYLVANIA STATE UNIVERSITY ACC-1975

Kenneth W. Hylbert, Ed.D.
Director
Rehabilitation Education Programs
College of Education
323 Social Science Building
University Park, Pennsylvania 16802

UNIVERSITY OF PITTSBURGH ACC-1975

Richard E. Desmond, Ph.D.
Director
Rehabilitation Counseling Program
School of Education
4616 Henry Street
Pittsburgh, Pennsylvania 15260

UNIVERSITY OF SCRANTON ACC-1975

Joseph A. Szuhay, Ph.D.
Director
Rehabilitation Counseling Program
Graduate School
Monroe and Linden Streets
Scranton, Pennsylvania 18510

SETON HALL UNIVERSITY ACC-1976

Ernest L. Tamburri, Ed.D.
Director
Rehabilitation Counselor Education
Department of Counseling and Special Services
School of Education
South Orange, New Jersey 07079

UNIVERSITY OF SOUTH CAROLINA ACC-1976

Jay M. Allen. Ph.D
Coordinator
Rehabilitation Counselor Training
College of Education
Columbia, South Carolina 29115

UNIVERSITY OF SOUTHERN CALIFORNIA ACC-1976

Rosemary Callahan, M.Ed.
Director
Rehabilitation Counseling Program
Department of Counselor Education
503 Phillips Hall
University Park
Los Angeles, California 90007

SOUTHERN ILLINOIS UNIVERSITY ACC-1976

Brockman Schumacher, Ph.D.
Coordinator
Rehabilitation Counselor Training Program
Rehabilitation Institute
Carbondale, Illinois 62901

SAINT CLOUD STATE UNIVERSITY ACC-1976

Eugene Perkins, Ed.D.
Director
Rehabilitation Counselor Education
College of Education
Saint Cloud, Minnesota 56301

STATE UNIVERSITY OF NEW YORK AT ALBANY ACC-1975

Sheldon A. Grand, Ed.D.
Director
Rehabilitation Counselor Education
Department of Guidance and Personnel Services
1400 Washington Avenue
Albany, New York 12203

STATE UNIVERSITY OF NEW YORK AT BUFFALO ACC-1976

Marceline E. Jacques, Ph.D.
Director
Rehabilitation Counselor Education
Faculty of Educational Studies
27 Foster Annex
3435 Main Street
Buffalo, New York 14214

SYRACUSE UNIVERSITY ACC-1975

Lawrence B. Feinberg, Ph.D.
Professor and Director
Rehabilitation Counselor Education
Division of Special Education
and Rehabilitation
School of Education
Syracuse, New York 13210

THE UNIVERSITY OF TEXAS AT AUSTIN ACC-1975

Carl E. Hansen, Ph.D.
Rehabilitation Counselor Education
Department of Special Education
Sutton Hall
Austin, Texas 78712

UNIVERSITY OF UTAH ACC-1975

J. Blair Stone, Ph.D.
Professor
Department of Educational Psychology
Graduate School of Education
Salt Lake City, Utah 84112

VIRGINIA COMMONWEALTH UNIVERSITY ACC-1976

Richard E. Hardy, Ph.D.
Director
School of Rehabilitation Counseling
901 West Franklin Street
Richmond, Virginia 23220

WEST VIRGINIA UNIVERSITY ACC-1975

Jeffrey K. Messing, Ph.D.
Professor and Chairman
Departments of Counseling and Rehabilitation
College of Human Resources and Education
509 Forestry
Morgantown, West Virginia 26505

THE UNIVERSITY OF WISCONSIN AT MADISON ACC-1976

Alfred J. Butler, Ph.D.
Coordinator
Rehabilitation Counselor Education
Department of Studies in
Behavorial Disabilities
2605 Marsh Lane
Madison, Wisconsin 53706

THE UNIVERSITY OF WISCONSIN AT MILWAUKEE ACC-1975

Ann B. Trotter, Ph.D.
Coordinator
Rehabilitation Counseling
Department of Educational Psychology
Enderis Hall
Room 757
Hartford Avenue
Milwaukee, Wisconsin 53201

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION
520 North Michigan Avenue—Suite 1504
Chicago, Illinois 60611

CERTIFIED REHABILITATION COUNSELOR SUPERVISOR RATING FORM

Name of Rehabilitation Counselor Candidate: _____

* * * * *

I CERTIFY THAT THE ABOVE NAMED APPLICANT RECEIVED A SYSTEMATIC AND PERIODIC EVALUATION OF THE QUALITY OF HIS/HER DELIVERY OF SERVICE WHILE UNDER MY SUPERVISION.

Place of Employment: _____

Date of Employment: _____ Job Title: _____

Responsibilities: _____

_____

_____

Please respond to the following statements while asking yourself: "How satisfied am I with this aspect of the applicant's response to supervision?"

THE ABOVE NAMED CANDIDATE:	Dissatisfied	Neutral	Satisfied	Very Satisfied	Extremely Satisfied
1. Accepted supervision with a positive attitude.	☐	☐	☐	☐	☐
2. Responded to supervision with appropriate changes in professional behavior.	☐	☐	☐	☐	☐
3. Related the needs of individual clients to basic rehabilitation concepts.	☐	☐	☐	☐	☐
4. Demonstrated noticeable growth in the use of rehabilitation counseling skills and techniques.	☐	☐	☐	☐	☐
5. Improved in the delivery of those services which were evaluated.	☐	☐	☐	☐	☐
6. Used evaluation to improve working constructively with peers.	☐	☐	☐	☐	☐
7. Initiated personal goals for self-improvement.	☐	☐	☐	☐	☐
8. Has performed duties as outlined in the Code of Ethics.	☐	☐	☐	☐	☐

9. Additional Comments: _____

_____

_____

Name of CRC Supervisor _____
please type or print

Date Certified: _____; ID Number: _____

Address: _____

SIGNATURE: _____

Thank you for your time and assistance.

HISTORY OF PROFESSIONAL EXPERIENCE

3. Employer: _____

Address: _____

Name of Supervisor: _____ Title: _____

Dates of Employment: From _____ (Month/Day/Year) to _____ (Month/Day/Year) Total Number of Months _____

Job Title: _____

Detailed Description of Duties: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Employer: _____

Address: _____

Name of Supervisor: _____ Title: _____

Dates of Employment: From _____ (Month/Day/Year) to _____ (Month/Day/Year) Total Number of Months _____

Job Title: _____

Detailed Description of Duties: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Use Additional Pages if Necessary.

Code of Ethics

A rehabilitation counselor has a commitment to the effective functioning of all human beings; his emphasis is on facilitating the functioning or refunctioning of those persons who are at some disadvantage in the struggle to achieve viable goals. While fulfilling this commitment he interacts with many people, programs, institutions, demands, and concepts, and in many different types of relationships. In his endeavors he seeks to enhance the welfare of his clients and of all others whose welfare his professional roles and activities will affect. He recognizes that both action and inaction can be facilitating or debilitating and he accepts the responsibility for his action and inaction.

- The primary obligation of the rehabilitation counselor is to his client. In all relationships he will protect the client's welfare and will diligently seek to assist the client towards his goals.
- The rehabilitation counselor recognizes that the client's family is typically a very important factor in the client's rehabilitation. He will strive to enlist the understanding and involvement of the family as a positive resource in promoting the client's rehabilitation plan and in enhancing his continued effective functioning.
- The rehabilitation counselor is obligated to protect the client-employer relationship by adequately apprising the latter of the client's capabilities and limitations. He will not participate in placing a client in a position that will result in damaging the interests and welfare of either or both the employer and the client.
- The rehabilitation counselor will relate to his colleagues in the profession so as to facilitate their ongoing technical effectiveness as professional persons.
- Typically, the implementation of a rehabilitation plan for a client is a multi-disciplinary effort. The rehabilitation counselor will conduct himself in his interdisciplinary relationship in such a way as to facilitate the contribution of all the specialists involved for maximum benefit of the client and to bring credit to his own profession.
- The rehabilitation counselor will be loyal to the agency that employs him and to the administrators and supervisors who supervise him. He will refrain from speaking, writing, or acting in such a way as to bring discredit on his agency.
- The rehabilitation counselor will regard his professional status as imposing on him the obligation to relate to the community (the public) at levels of responsibility and morality that are higher than are required for persons not classified as "professional." He will use his specialized knowledge, his special abilities, and his leadership position to promote understanding and the general welfare of handicapped persons in the community, and to promote acceptance of the viable concepts of rehabilitation and of rehabilitation counseling.
- In his relationships with other programs, agencies and institutions that will participate in the rehabilitation plan of the client, the rehabilitation counselor will follow procedures and insist on arrangements that will foster maximum mutual facilitation and effectiveness of services for the benefit of the client.
- The rehabilitation counselor is obligated to keep his technical competency at such a level that his clients receive the benefit of the highest quality of services the profession is capable of offering.
- The rehabilitation counselor is obligated to assist in the efforts to expand the knowledge needed to serve handicapped persons with increasing effectiveness.

STATEMENT OF UNDERSTANDING

I hereby apply for Certification to the Commission on Rehabilitation Counselor Certification and ascribe to the Code of Ethics printed on this Application. I understand that Certification depends upon my successfully completing the assessment of competence procedures established by the Commission including submission of all required documents and references and achieving a minimum passing score on the Certification Examination. I also understand that for research and statistical purposes only, data resulting from my participation may be used in an unidentifiable manner.

Signature _____ Date _____

Member Organizations of the Commission are:

American Rehabilitation Counseling Association	ARCA
National Rehabilitation Counseling Association	NRCA
National Council on Rehabilitation Education	NCRE
Council of State Administrators of Vocational Rehabilitation	CSAVR
Association of Rehabilitation Facilities	ARF
Council on Rehabilitation Education	CORE
National Association of Non-White Rehabilitation Workers	NANWRW
American Coalition of Citizens with Disabilities, Inc.	ACCD

MICHIGAN STATE UNIVERSITY

COLLEGE OF EDUCATION · DEPARTMENT OF COUNSELING, PERSONNEL SERVICES AND EDUCATIONAL PSYCHOLOGY · EAST LANSING · MICHIGAN · 48824

June 7, 1978

Dr. Roger Livingston, Assistant
Professor
Educational Psychology Clinic
The University of Nebraska-Lincoln
130 Bancroft Hall
Lincoln, Nebraska 68588

Dear Roger:

As chairperson of the research committee for CRCC, I have received the article, "A Time for Change? Implications of the CRCC Demographic Data for Rehabilitation Curriculum." I believe it reflects the data accurately with some challenging interpretations. I am sending a copy of this response and a copy of the article above to Dr. Dan McAlees, as chairperson of the CRCC. I recommend that it be published and unless I hear otherwise from Dan, you may proceed with publication.

Regards,

James R. Engelkes
Associate Professor

JRE/lgr

cc: Dr. Dan McAlees

A Time for Change?

Implications of the CRCC Demographic Data for Rehabilitation Curriculum

Roger H. Livingston
Assistant Professor
University of Nebraska-Lincoln

BIOGRAPHICAL SKETCH

Roger Livingston, Ph.D., is an Assistant Professor of Counseling Psychology and Coordinator of the Rehabilitation Counselor Training Program at the University of Nebraska-Lincoln.

ABSTRACT

A Time for Change?

Implications of the CRCC Demographic Data

for Rehabilitation Curriculum

Since mid-1975, extensive data has been collected on individuals seeking to become Certified Rehabilitation Counselors. Examining the data on "counselors" suggests that performance on the Field Review is below average in some situations. Graduates of rehabilitation counseling programs tend to score higher than most other graduate majors, such as counseling psychology or clinical psychology. The results suggest steps should be taken to strengthen training for the rehabilitation professional in terms of graduate education, RCEP, and in-service training.

The data used in this article is the property of the Commission of Rehabilitation Counselor Certification.

Tables reporting the results and information on the data pool may be obtained from the author.

A TIME FOR CHANGE? IMPLICATIONS OF THE CRCC DEMOGRAPHIC DATA FOR REHABILITATION CURRICULUM

The enactment of the Vocational Rehabilitation Act of 1954 (PL 83-565) made available training grants that provided incentive for many universities and colleges to begin rehabilitation counseling education (RCE) programs. Numerous conferences on rehabilitation counselor education and research studies on the role and function of rehabilitation counselors were conducted to aid in the development of curriculum guidelines. The guidelines that resulted were not inclusive and specific courses and content became the responsibility of the administrators of RCE programs. In a recent study by the Council of Rehabilitation Education (CORE) related to the establishment of accreditation procedures for master's level rehabilitation counseling programs, a difference was found with respect to the emphasis placed on various aspects of counselor training (Wright, Reagles & Skorzelli, 1973). With the enactment of the Rehabilitation Act of 1973 came additional impetus for training and for the formation of Regional Continuing Education Programs (RCEP). The two forms of training, RCEP and RCE programs, along with in-service training are the basis for rehabilitation counselor training.

"A Statement of Policy on Professional Preparation of Rehabilitation Counselors" was revised in October 1974 by the American Rehabilitation Counseling Association. Section III D of this document states, "Curriculum evaluation procedures should provide for adequate feedback by students, alumni, clients, supervisors and employers." At the present time, there appear to be two mechanisms to obtain this feedback. One is through the accreditation of university training programs, and the other is the certification of practitioners.

In each situation, an attempt is being made to insure minimal competencies of individuals within the profession.

A basic goal of university graduate training is to prepare an individual with basic knowledge and skills of the profession and to instill a commitment to update continually such knowledge and skill upon graduation. Usually, a basic goal of the student is to get the degree and get a job. A responsibility of the university, then, is to instill the motivation and perceived need of continued training within the student (Engelkes & Livingston, 1977). Demographic data collected on individuals seeking certification revealed that many of the CRC's have either taken a class in a university (24%) or attended a workshop or institute (51%) in the last year and that 46% of the CRC's are engaged in in-service training activities between one and four hours per month. Apparently, then, many individuals do continue their training.

One way of assessing this training and of obtaining feedback, whether it be from a rehabilitation counselor training program, rehabilitation counseling continuing education program, or in-service, is to examine the possible influences this training has on individuals taking the CRCC Field Review examination. However, the "Field Review examination is a practice-based examination" and "items included in the examination put a higher premium on the application of knowledge in managing clients rather than on isolated bits of factual information" (McAlees, 1975, p. 162).

CERTIFICATION DATA

The research committee of CRCC designed a more comprehensive demographic questionnaire in the spring of 1975 that has now been used with approximately 5,000 applicants for certification. A number of these demographic variables speak to the area of training. Also, there appears to be a strong relationship

between the content areas of the CRCC Field Review examination and Section III of the ARCA guidelines for professional preparation, which reflects the current thinking on curriculum needs for preparing rehabilitation counselors.

The data to be discussed in this paper is from an analysis of the July and October 1975 and April 1976 Field Review data. A total of 3,557 demographic forms served as the data pool and were compared to Field Review test results on three forms of this examination. The reader should be cautioned that the responses reflect only those individuals who applied for rehabilitation counselor certification during the last year of the "grandpersoning" period. Generalizations, then, may be drawn to all other rehabilitation counselors who may have been motivated to become certified during this time period but for some reason did not do so.

This paper discusses (1) ratings of training versus Field Review performance, (2) performance of counselors and rehabilitation counseling majors on the Field Review, (3) ratings on the helpfulness of in-service training, (4) regional Field Review performance, and (5) regional training needs.

RATINGS OF TRAINING VERSUS FIELD REVIEW EXAMINATION PERFORMANCE

Ratings of training were compared to actual performance in a given area. Nine variables -- blind, deaf, group counseling, counseling theory, job development and placement, mental retardation, community organization and resources, case management, and medical aspects of disability -- were isolated for which sub-test scores and ratings of training could be contrasted. Of particular interest was how individuals who indicated "no training" in a given area performed versus those who rated their training from "poor" to "excellent".

An initial analysis was made of ratings of training by sub-test performance in the nine areas for all 3,557 subjects. There was a tendency to

rate centrally at or near the mid-point of the scale but there was generally no consistent relationship between sub-test performance and the ratings. This includes individuals who indicated they had "no training" in a specific area. The one notable exception was in the area of counseling theory, where those indicating "no training" performed consistently lower than all others.

An analysis of individuals who indicated that their areas of specialization in practice as "counseling" and of individuals who indicated that they held master's degrees in rehabilitation counseling indicated that respondents specializing in "counseling" and indicating "not at all" in the nine subject areas obtained the lowest scores 43% of the time and of those indicating training as "excellent", only 23% received the highest scores. In this analysis, as when examining all participants, there was no consistent pattern in ratings of training and sub-test performance in the given areas.

For the group indicating that they held master's degrees in rehabilitation counseling, it was found that those indicating "not at all" in the nine subject areas scored lowest 38% of the time. There was a moderate increase to 30% for those indicating training as "excellent" in receiving the highest scores. The content area of "group counseling" may require closer scrutiny as a result of these analyses. On all administrations of the Field Review in this analysis, the individuals indicating "not at all" in this area obtained the highest scores and 60% of the time those indicating "excellent" received the lowest scores.

"COUNSELOR" PERFORMANCE

To further assess the performance of certification applicants, an analysis was made of total test score performance by area of specialization in practice. The results reveal that there were significant differences among groups for

all three administrations of the Field Review. In July, the source of the difference was found between Rehabilitation Education and Disability Determination; in October, between Rehabilitation Education and Job Development and Placement. In April, a single individual in Disability Determination scored the highest, but Rehabilitation Education again had the highest mean scores. It seems logical that the rehabilitation educators group would perform at a higher level than non-educators. However, this is somewhat inconsistent with the notion that less emphasis is placed on isolated bits of factual information and more emphasis on managing clients. Perhaps these educators have functioned as rehabilitation counselors and have retained sufficient knowledge through teaching the practice of rehabilitation counseling.

Mean sub-test scores for "counselors only" were compared to all other areas of specialization combined on the following eight sub-tests: (1) rehabilitation planning, (2) case management, (3) information dissemination, (4) vocational counseling, (5) personality and adjustment counseling, (6) group counseling, (7) job development and placement, and (8) vocational and psychological assessment. These eight sub-tests were selected as areas in which rehabilitation counselors might demonstrate a higher skill level than in other areas of practice. The analysis revealed that this was not true. With one exception, there were no consistent patterns for which one group or the other scored consistently higher. This one area of exception was case management, where "counselors" scored higher 80% of the time.

Performance patterns on a regional basis were also examined. In July 1975 and April 1976, the "counselor" group scored higher than all other groups combined in only four regions. In July, the Regions were IV, VI, VIII, and IX. In April they were Regions II, III, VI, and IX. However, in October 1975, the

"counselor" group scored higher in six regions, including I, III, IV, VI, VIII, and X. The only regions to score consistently higher were VI and IX. These results are not particularly encouraging since this group is the one providing direct services to rehabilitation clients. Greater focus on quality assurance of services provided to clients may be the necessary next step in these regions. This may be true particularly in Regions V and VII where the "counselor" group was consistently out-scored by the other groups.

REHABILITATION COUNSELING GRADUATE MAJORS

To assess the impact of counselor training on Field Review performance, graduate majors in rehabilitation counseling were compared to all other graduate majors combined. In July and April, counseling psychology majors scored higher on the average, and in October 1975, clinical psychology majors scored higher on the average. A Tukey post hoc analysis was completed and no significant differences were found between any of the groups. In other words, even though other graduate majors scored higher on the average, there was no statistical difference in the scores obtained.

Since no differences were detected in the Field Review examination scores between rehabilitation counseling majors and all other graduate majors, it was hypothesized that the rehabilitation counseling majors would score higher on areas directly related to rehabilitation. This hypothesis was overwhelmingly confirmed. From the 33 sub-tests across six different forms of the Field Review, it was found that rehabilitation counseling majors scored higher than the other groups combined in 11 areas. These areas included: (1) adult, (2) deaf, (3) medical and psycho-social aspects o disability, (4) counseling theory, (5) rehabilitation planning, (6) personality and adjustment counseling, (7) neurologically impaired, (8) staff development, (9) three rather nondescript areas

labelled "other", (10) general information, and (11) recall. Rehabilitation counseling majors also scored higher than the other groups 80% of the time in the following 15 areas: (1) child, (2) physical disability, (3) emotional disorders, (4) mental retardation, (5) occupational information, (6) counseling methods, (7) personal vocational adjustment, (8) research utilization, (9) information dissemination, (10) vocational counseling, (11) group counseling, (12) job development and placement, (13) vocational and psychological assessment, (14) community organization and resources, and (15) interpretation skills. These results strongly suggest that those trained specifically in rehabilitation cousneling perform better than other graduate majors on these 26 sub-tests of the Field Review examinations listed above. Interestingly, had the performance of rehabilitation counseling majors continued as it did in July and October 1975, the number of areas in which they scored higher across all administrations and forms of the examination would have been greater. There is a possibility that the Field Review is becoming more field based, as it is intended to be, as it becomes refined through repeated administrations, and that this is the reason for the lower scores by rehabilitation counseling majors during the April administration. The question must remain unanswered until additional data is collected in future administrations of the examination.

Again, to further clarify performance patterns, comparisons of the aforementioned groups by region was made in an attempt to discern if any one region might have been pulling down the overall performance of rehabilitation counseling majors. In July 1975, rehabilitation counseling majors scored lower in Regions I and VIII. In October 1975, it was Regions II, V, and VIII, and in April 1976, Regions IV, V, and IX. There was no one region that scored consistently lower; however, Regions V and VIII did appear two of three times.

IN-SERVICE TRAINING

In the demographic questionnaire, the following question was asked: "Describe the extent to which your total current in-service training program helps you in performing your job: (1) rarely, (2) sometimes, (3) frequently, (4) generally, (5) almost always." The results of an ANOVA utilizing total test scores revealed no statistically significant differences between groups in July, but differences were noted in both October and April administrations of the Field Review. Interestingly, those individuals indicating that their current in-service training was "rarely" helpful scored higher on the average than any other group on all three occasions. In October, mean scores were inversely related to the helpfulness of training. These analyses suggest that either the CRC's are already familiar with in-service materials and, consequently, indicate that these presentations are "rarely" helpful or, in fact, that this training is targeted at too low a level to provide the necessary components for them to improve their skills.

GENERAL CONCLUSIONS AND SUGGESTIONS

There may be some who would object to comparisons being made between groups in this paper because of a lack of validity data on the Field Review examination. It should be noted, however, that validity data does exist. For example, Lunz (1975) stated that "while refinement and improvement is still essential, the March 1975 Field Review measured similarly across educational groups, geographic groups and work setting experience . . . this suggests that the examination has content validity where the criterion is practice-based performance and internal consistency or test reliability across groups" (p. 71). Livingston (1976) conducted a concurrent validity study and found twelve statistically significant variables on which validity could be based. Finally,

the results of the analysis in this paper do suggest some construct validity. Even with these forms of validity established, the possibility does exist that the performance of certification applicants on the Field Review has no relationship to their actual performance in the field. However, one of the objectives of certification is to provide the consumer with an objective criterion to evaluate CRC's providing services. This criterion does exist in the form of Field Review results. Objections might also be raised because statistical differences were either not tested or detected in these analyses. All of these factors may be true, but the consistency of the results is indicative of some differences and does warrant our attention.

The National Council on Rehabilitation Education has collected data on rehabilitation counseling majors that indicates that approximately 17% of the rehabilitation majors move to another geographical area after graduation, but this still leaves 83% remaining in a given region. Total test score performance by region was examined and as an example, Region VI had the lowest mean scores on two of three administrations, whereas Region VIII scored the highest. Are we content with our regional performance? Do we want or need to make changes?

When it is noted that a particular region's counselors who are the first-line providers of direct services to clients score consistently lower, one might be curious about the quality of services provided to rehabilitation clients. When the findings reflect that counselors in the field feel that their in-service training is helpful to them in performing their jobs only 50% of the time, the question of the content of the in-service arises.

Those trained in rehabilitation counseling appear to be performing adequately on the Field Review as compared to other groups. But, they do not do so consistently, which may speak to the variability of rehabilitation counselor

training programs. This area may need to become unified if programs are to meet accreditation standards and if graduates are to complete certification requirements by examination.

The question at this point appears to be "how do we begin this change?". I would like to propose that, first, we examine CRC performance for both "counselors" and "rehabilitation counseling majors" to determine if we are content with their performance and our training efforts in the specific areas. Secondly, I would suggest that we closely examine the data pool containing the responses to questions related to how well the training the CRC applicants received prepared them for work as rehabilitation counselors. There are categories that are of minimal importance, such as accounting and use of AV equipment, but there are others such as sexual dysfunction in which 985, or 28%, of the group under study have received "no training". In the subject areas of "deaf" and "blind", we find approximately 30% of the group in this study had "no training" in these areas and that 25% feel that they do need additional training. In the area of "placement", which is considered to be the primary goal of rehabilitation, we find that 13% of the group has had "no training" and that 24% of them feel that they need more training. There are a number of areas including: (1) alcoholism, (2) behavior modification, (3) blind-deaf, (4) drugs, (5) job objectives, (6) family treatment, (7) grant proposal writing, and (8) management training in which 25% to 30% of the CRC's are requesting additional training.

The next logical approach is to determine where the CRC's desiring this training are located. This data currently exists within the CRCC data pool and should be examined by both educators and trainers in the rehabilitation profession. An example should provide clarity. In looking at the content

area of "placement", an area in which there was mixed performance by the "counselor only" group, one finds for the group under study that in Region I, 23% of all CRC's from that region desire additional training in this area; for Region II, 16%; Region III, 27%; Region IV, 26%; Region V, 28%; Region VI, 20%; Region VII, 29%; Region VIII, 21%; Region IX, 22%; and Region X, 18%.

This author believes that the mixed performance by the "counselor only" group, the lack of consistent performance by the "rehabilitation counseling major" group, the indication of receiving "no training at all" in significant areas, and the desires expressed by CRC's for additional training warrant changes in current curriculum offerings and/or increased training by the RCEP's in these areas in conjunction with more relevant in-service efforts.

These data raise provocative questions regarding the future of rehabilitation education and future curriculum content. Data will continue to be collected and, hopefully, they will clarify and point out future directions for rehabilitation curriculum. The practicing, experienced rehabilitation counselor should also attend to the results presented. The collective voices of these individuals should be heard by all individuals providing training so that timely and relevant training is provided. The provision of appropriate training should improve upon the already existing skills of rehabilitation professionals, thus improving the quality of services provided to clients. The practicing rehabilitation counselor is accountable to his or her client and educators/trainers are responsible for providing quality education to enhance the performance of rehabilitation counselors.

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NOVEMBER-DECEMBER
1977

Journal of REHABILITATION

Highlights of the 1977 NRA National Conference

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Dr. Edwin W. Martin

NRA Awards Luncheon

NRA Congressional Breakfast

Secretary Joseph A. Califano, Jr.

National Rehabilitation Association

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The NRA: A Gentle Giant

Richard P. Oestreich
Executive Director, NRA

I sometimes feel in this business like I did when once I was to meet my wife on the southeast corner of a building and waited an hour while she patiently stood on the southwest corner (or was I on the northeast?).

By the time we finally got together we recited a chorus of: "Where-have-you-been?"; "God, don't you ever listen to me?"; and "Next time let's . . ."

The fact is we were both there, but we neither listened, nor planned, nor met.

"Where has the NRA been?" "Where has the VR program been?" "Where is our sensitivity to the disabled?"

Folks, let's stop the finger-pointing and the ego-puffing and the stone throwing and the impatience and simply get down to the work of meeting.

For those of you who don't give a damn about the blind and disabled or about advocating for them or serving them in a sound professional way, no message is cogent.

For those who feel that the sun rises and sets on this business of rehabilitation and advocacy and independent living for the not-so-able-bodied,—let's get on with it. You are right!

The tiger you have by the tail is cost-effective, humanistic, populist,—*avant-garde* even.

The NRA is not going to follow the whims and backroads of frustration. Together we can lead the charge: that relentless, undaunted, steady push for our cause.

Where have we been? Right here, the whole time. Occasionally we've been too quiet, shy, confused and angry; but we've been here.

NRA is an attitude, more than anything else. It is the courage to speak on behalf of, suffer embarrassment for and start over many more times than we care to in this movement generally called Rehabilitation.

The coming twelve to twenty-four months hold great challenges to hold strongly to existing and new legislative structures and attitudes.

The strength is there among you. Let's rise to the challenge of national health insurance, welfare reform, independent living, VR appropriations, no-fault insurance, long-term care, incentives to independence, state organizational structures, and others.

To close let me borrow a dedication from Peggy Bendrick, R.N.(T.O.O.L.S. 12/25/76)

Dedicated to People

Those with disabilities
And those without
Those who are disabled
And know it not
I've managed to climb some mountains
And am scarred from slipping
And falling
Hurting and crying; but
Determination defies defeat
To those faced with like ascent
Of ominous, threatening heights
Please, take my hand
Come roll with me.

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Membership dues are $30.00 a year; associate membership, $15.00; student membership, $15.00. Also offered are sustaining memberships, and memberships for organizations. All include a subscription to the official magazine and to the NEWSLETTER, published in alternate months. Single copies of the JOURNAL, $2.00.

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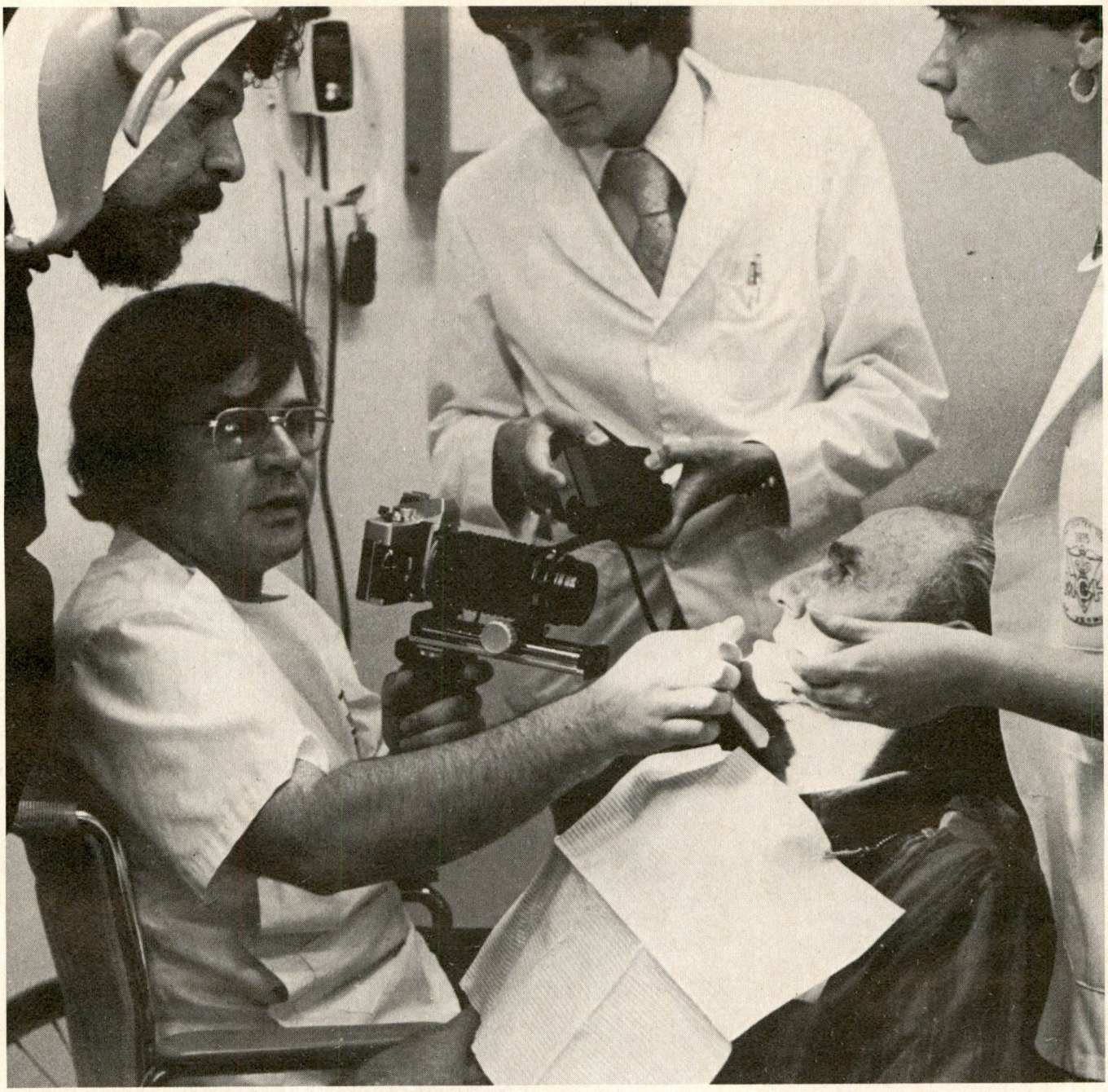


Dr. Mark Swerdloff and associates check a patient's progress at the State University of New York at Stonybrook.

"Everything is foot-operated. patients – how can he work – when

Brooklyn, New York. November, 1968. Second-year dental student Mark Swerdloff and a friend are pushing a stalled car to the side of the road. Traffic stops behind them. Suddenly another car pulls around the waiting cars, shoots back into the front of the line. And crushes Mark against the stalled car. Mark loses both legs, each above the knee.

A time of adjustments.
Months of hospitalization were followed with more months of rehabilitation therapy. Mark says, "I had to go through my period of psychological adjustment. For the first two months I cried every single day."

But Mark was determined to get his life back under control. And with the help of skilled professionals, good friends, and family – he did.

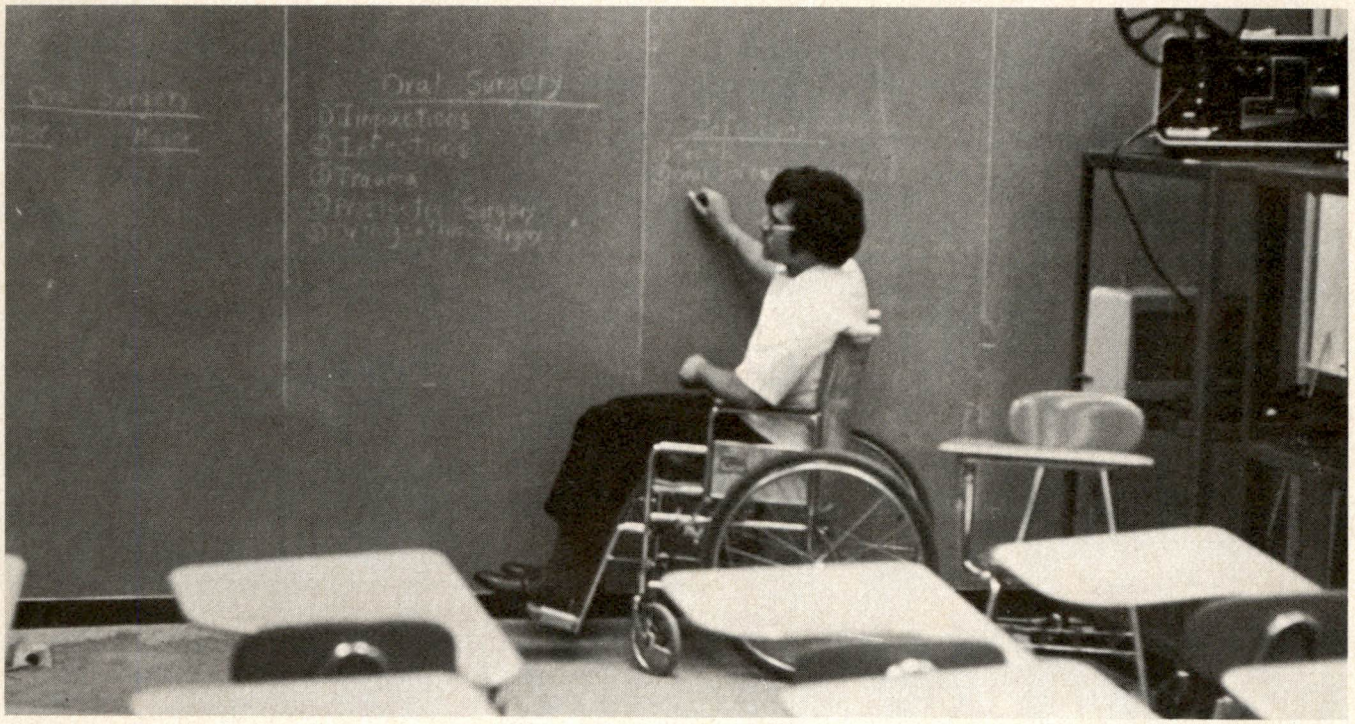
Just a few months later than they originally planned, Mark and his fiancee were married. And in the fall of 1969 Mark returned to dental school.

Reluctances to overcome.
Many among the administrators and faculty were reluctant to accept Mark back into dental school. They wondered, for example, how he could treat patients when most dental equipment was foot-operated.

That obstacle was overcome with the help of a fellow student who rewired an entire unit to make it hand-controlled.

There were other concerns as Mark progressed. Though he was graduated from dental school at the top of his class, he had to convince authorities that he was able to handle the physical demands of the oral surgery residence program that was his next objective.

Dr. Swerdloff's schedule requires careful attention to paperwork, checking on patients' records, and preparation for classroom lectures.



How is he going to treat everything is foot-operated?"

Mark overcame their reluctance by voluntarily spending several days and nights showing the work he could do under supervision.

Assistant Professor of Oral Surgery. In June of 1975, Mark completed his residency. In September of that year, he began teaching at the State University of New York at Stonybrook. Of his double amputation, Mark now says, "There's no answer to the question 'Why was I chosen?' I can't say I've fully accepted it. But I've certainly adjusted to the fact. And to the realization that I'm doing in life what I want to do."

Helping people do what they want to do. That's why Everest & Jennings came to be.

Our business began when Herbert Everest, who had lost the use of his legs in a mine cave-in, wanted a folding wheelchair to enable him to make greater use of his automobile. His friend Harry Jennings designed and built it for him.

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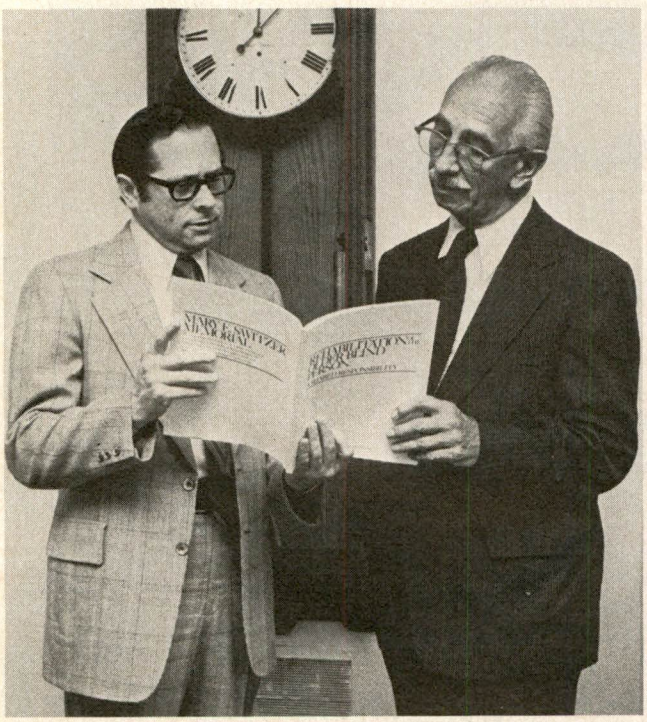
Special Products for Special Needs

Mary E. Switzer Second Seminar Report Commands International Attention

The NRA national office recently received a letter from a consultant to the Australian National Advisory Commission for the Handicapped. The writer noted that the findings and recommendations of the Mary E. Switzer Seminar have been used to formulate policy development in this area and indicated further that the "issues raised at the 'Mary E. Switzer Seminar' were remarkably similar to those raised in Australia through a consultative process, undoubtedly reinforcing the fact that these are current universal problems and international solutions are required for creating positive impact."

The NRA has just announced the publication of the Second Mary E. Switzer Memorial Seminar, *The Rehabilitation of the Older Blind Person: A Shared Responsibility.* The report contains five chapters, each serving as the major points of discussion at the seminar held in New York City, January 1977. Each chapter provides a summary with implications for action in program and policy development, research, and recommended legislation.

Leonard G. Perlman, Ed.D., Seminar Coordinator, also served as editor of the report, which was a joint undertaking of private sector, The Administration on Aging, and the Rehabilitation Services Administration (OHD/DHEW). Those interested in receiving a copy of the report, please send a check or money order of $2.00 for postage and handling to: Mary E. Switzer Memorial Fund, c/o National Rehabilitation Association, Suite 1120, 1522 K Street, N.W., Washington, D.C. 20005.



Dr. Leonard G. Perlman is shown presenting a copy of the Second Mary E. Switzer Memorial Seminar, *The Rehabilitation of the Older Blind Person: A Shared Responsibility,* to Mr. Willis Atwell, Director of Field Staff Liason, Administration on Aging, Washington, D.C.

MDs Attending Symposium On Minimal Brain Dysfunction Experience "Feel" Of MBD; Their Role As "Coordinator" Stressed

What does the child with minimal brain dysfunction experience in his daily life? Physicians and other child specialists attending a symposium on MBD found out when they participated in a number of learning disability tests designed to help them actually get the feel of the condition.

Joanna S. Davis, M.S., Language and Education Specialist at the University of Arkansas for Medical Sciences in Little Rock, where she is Assistant Professor, Department of Psychiatry, conducted the tests and reports that many of the participants who had thought they "understood" found that they had not "felt" what MBD was really like heretofore—the frustration and the confusion that the child experiences.

Minimal brain dysfunction refers to children with specific learning or behavioral disabilities associated with deviations of functioning of the central nervous system. There are an estimated 3,000,000 MBD children in the U.S.

These are children who are often disruptive in school and at home, may talk out of turn, or touch things much like youngsters years younger than themselves. They may be volatile, impatient, clumsy, unpredictable in their behavior.

Treating the MBD child requires the skills of several child specialists, another faculty member, clinical child psychologist, Sam D. Clements, Ph.D., told the symposium. Dr. Clements, Professor, Department of Psychiatry, University of Arkansas for Medical Sciences, stressed the need for a special neurological examination, individual psychological testing rather than group testing, language and educational screening. Home and school performance must also be evaluated.

"It is frequently concern by teachers and other school officials about the learning and behavior of a child who otherwise appears normal that starts the process of finding out what is wrong with the child," Dr. Clements observed.

He said that an MBD child's learning disability may cause him to appear retarded, when in fact he usually has average or above average intelligence.

Dr. Clements stressed the importance of individualized handling of children with learning disabilities. He said that with proper briefing of regular teachers, many MBD children can spend most of their school time in regular classes and receive remedial instruction or work in special resource rooms for an hour a day.

Another faculty member, Cleo M. Goolsby, M.S.W., Psychiatric Social Worker and Assistant Professor, Department of Psychology at the same institution, suggested that the pediatrician or family physician be prepared to take on the task of coordinating medical and educational approaches for the MBD child.

"Parents are often caught between specialists who are not in touch with each other. They become frustrated if a psychologist tells them one thing, the pediatrician another, and the teacher still another. They usually welcome the physician offering to serve as the liaison for all of the professionals involved in working with the child," he stated. "Fundamental to the establishment of a unified, cooperative approach is the development of mutual trust between physician and educator," she added.

The symposium on minimal brain dysfunction was sponsored by the Division of Child and Adolescent Psychiatry, the University of Arkansas for Medical Sciences and CIBA Pharmaceutical Company, as part of its Medical Horizons Postgraduate Education Series for Physicians.

More Handicapped Students Expected By Nation's Colleges, Universities

Recently passed federal legislation states that handicapped persons must have equal access to college and university campuses, and one expert believes the number of handicapped persons on the nation's campuses will increase.

While at Wright State University for a national conference on "The Disabled Student on American Campuses: The State of the Art," Dr. Thomas Shworles, director of the Center for Program Development and the Handicapped at the City Colleges of Chicago, said that he expects an increase in handicapped adults on American campuses, but believes the federal legislation will not be the only reason.

Shworles said two major trends are becoming clear in handicapped student work. The first is that the word "handicapped", long associated with an individual, now is being applied to the services provided, the campus, itself, as opposed to the person.

Secondly, there is a growing acceptance of the handicapped persons as being normal. This, he says, shows a distinct shift in cultural thinking from the days when only the able-bodied were considered normal.

Shworles said both ideas are based on one principle: "the idea of 'handicappedness' finds it origins in society's physical and social values, not from within the individual person."

This means that all colleges and universities will have to establish and publish solid guidelines and principles for handicapped student services programs at the post-secondary level. Shworles acknowledges the limited funds, but believes that the objective of equal opportunity for the handicapped can be accomplished. "The post-secondary institution should provide services or meet the needs of disabled students in as normal a way as possible," he said.

Funded by the Bureau for the Education of the Handicapped, the national conference on "The Disabled Student on the American Campuses: The State of the Art" was the first of its kind ever held, according to Ed Martin, Deputy Director of the Bureau and Melvin Ladson, Jr., Projector Coordinator for the Bureau.

At mid-week, part of the group organized themselves into the National Association for Students with Handicaps to keep their exchange of information more frequent. Over 200 representatives from colleges and universities in 42 states attended the conference.

Immunological Protection For Unborn Infants Studied At Placental Tissue Registry

New insights about birth defects and problem pregnancies may result from continued research in a one-of-a-kind medical registry program based at Michigan State University. Sponsors of the registry, founded in 1970, include the Michigan Department of Health and the Michigan State Medical Society.

Pathologists at the Placental Tissue Registry are studying the placenta, the endocrine organ which surrounds the unborn infant and serves as a lifeline from mother to child. It frequently is discarded after superficial examination at childbirth.

Requests to physicians and Michigan hospitals have brought placental tissue from births marked by infant death, abnormalities in surviving babies, and maternal complications during pregnancy, such as diabetes, toxemia, and abnormal bleeding. Patient information on mother and infant accompany the specimens. Results from individual studies are disseminated to those concerned with care of the pregnant patient and her child.

Analysis of the registry's first 500 cases points to a continuing need for further research on the immunological role of the placenta in protecting the unborn infant. This is the view of Dr. Charles H. Sander, professor and associate chairman of MSU's Department of Pathology, who reported on placental tissue research at a special seminar at MSU's Clinical Center. His presentation included a paper by the registry's first director, the late Dr. Joseph Cipparone of Lansing's St. Lawrence Hospital.

"If there is exposure to viral infection during the first few months of pregnancy, the placenta may not be immunologically competent enough to react to the virus," Dr. Sander said. "The virus may pass unhindered from the mother through the placenta into the fetus, causing congenital anomalies or defects."

If viral exposure occurs later in pregnancy, the placenta may be more fully immunologically competent—and there is a battle fought within the placenta which prevents the virus from getting to the child, Dr. Sander suggested.

"Although this is conjecture and theory," he said, "the complexities of the placenta's protective role pose an important area for additional study."

Results from viral infection in the mother and infant during pregnancy, or even before pregnancy, are linked to a condition called chronic fibrosing villitis, a form of chronic placentitis which may be associated with infant malformations and even death.

Some viruses under suspicion as causes, according to Dr. Sander, are rubella (measles), vaccinia, and cytomegalic inclusion disease. Another suspect is a protozoan parasite called toxoplasma (toxoplasmosis), which also may cause fibrosing villtis and infant abnormalities. Selected cases from the registry are being studied using special techniques to localize antibodies in the placenta and more fully delineate this lesion.

Another placental condition sometimes but not always associated with infant abnormalities and infant death is aging of the maternal blood vessels, a process similar to that seen when fatty materials cause narrowing of blood vessels in adult tissues. This condition is often associated with hypertension and toxemia in the mother.

Other information arising from the placental research supports earlier findings calling for "examination at birth of the blood vessels of the umbilical cord to detect evidence of possible birth defects." Ten of 45 infants with birth defects in the placental tissue research were missing one of the usual

(Continued on Page 8)

Rehabilitation News

(Continued from Page 7)

two arteries in the umbilical cord.

"It behooves the obstetrician to examine the cord closely at childbirth," Dr. Sander affirms, "and to suspect a birth defect or anomaly in the newborn if an umbilical artery is missing."

Surgical Treatment of Cataracts Could Save Thousands From Blindness

Despite the availability of surgical procedures that are nearly 100 percent successful, cataracts remain one of the leading causes of blindness in the United States. Ironically, for many people it is the attempt to avoid the frightening prospect of blindness that causes them to neglect cataracts and eventually lose their sight.

But blindness caused by untreated cataracts is avoidable. In *Cataracts and Their Treatment,* a new Public Affairs Pamphlet, Arthur S. Freese explains what a cataract is, how it develops and forms, what effect it has on vision, the different kinds of cataracts. Freese then discusses when and how cataract operations are performed and, finally, how vision is regained after cataract surgery. The illustrated 24-page *Cataracts and Their Treatment* is available for 50 cents from the nonprofit Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

A cataract can be defined as a cloudiness or opacity in the lens of the eye which interferes with vision. "A cataract is neither a tumor nor an infection nor a film growing over the lens," Freese points out. "It is not contagious. Nor can it be 'cured' with either medication or exercises or gadgets. . . . Only proper surgery by legitimate and skilled opthalmologists can adequately treat this problem once it interferes with vision."

"In general," explains Freese, "cataracts can be classified as senile (those associated with aging), congenital (either hereditary or present at birth), traumatic (due to an injury), or secondary (those following some other eye disease). The great majority of cataracts are of the senile or degenerative type, which account for better than two-thirds of cataract operations." Freese says that in the United States "an estimated 75 percent of those aged 65 years and older will develop cataracts. However, for only 15 percent of these people will the cataract progress to the stage where vision loss interferes with normal activity; for less than 5 percent will surgery be needed."

Because there is no inflammation or pain connected with cataract formation, it is especially important to have regular check-ups and to be aware of warning signs and symptoms of cataracts. Freese outlines some of these as

—fuzzy, blurred vision—seeing as through a film
—double vision
—seeing spots
—need for frequent eyeglass prescription changes

Much progress has been made in recent years in understanding the causes of cataracts among the very young and among diabetics. But for the vast area of senile cataracts, knowledge is still limited, says Freese. Some day research may discover the causes of cataracts and develop preventive measures. For now, however, surgery is the only proven treatment. "Cataract surgery is a relatively simple but precise and delicate procedure," Freese points out. "It is done under either local or general anesthesia. . . . Most patients don't even feel any discomfort during the procedure, which usually takes less than an hour." Most patients are up and walking within 24 to 48 hours after surgery and out of the hospital within a week.

"After cataract surgery there is need for visual adjustments. . . . Today the opthalmologist has three answers to the problem created when a cataractous lens is removed: cataract eyeglasses, contact lenses, or—least frequently—lens implants."

Freese concludes: "So it has taken nearly 4,000 years for cataract surgery to reach the point of simple and near-total success. Now, too, there is much greater hope for comfortable vision after surgery. . . . With this hope, there is little reason for fear if you have to undergo surgery. Your own ophthalmologist is the best source of guidance on the latest advances and on the most appropriate treatment for you. For everyone, eye examinations should be part of health care and regular checkups. After age 40, have your eyes checked once a year—more frequently if you have an eye problem or a family history of eye disorders."

Cataracts and Their Treatment is No. 545 in the Public Affairs Pamphlet series, now in its 42nd year. This highly regarded series includes many other titles on physical and mental health, family relations, and social and economic issues. All pamphlets are 50 cents each; a list is available upon request.

1977 Graduate Literary Awards

The National Rehabilitation Association is pleased to announce the winners of the 1977 Graduate Literary Awards contest. They are: First Place, Mark Johnston; Second Place, Nancy Dawson; Third Place, Merry Buerschinger. All are graduate students of the University of Texas at Austin.

Liberty and Justice for All

INCLUDES RETARDED CITIZENS

National Association for Retarded Citizens
2709 Ave. E. East, Arlington, Texas 76011
Area Code: (817) 261-4961

National Rehabilitation Association

1522 K Street, N.W., Washington, D. C. 20005

Membership Application

Please print

Mr.
Mrs.
Ms.
( )

TITLE | FIRST NAME | MIDDLE INITIAL | LAST NAME

ADDRESS

CITY | STATE | ZIP

☐ New Member
☐ Renewal
☐ Current Member Adding Division(s) Only

NRA Annual Dues

- ☐ Member . . . . . $ 30.00
- ☐ Associate Member 15.00
- ☐ Student Member 15.00
  (Please sign student form at right)
- ☐ Sustaining Member . . . . . 50.00 $_____

Division Annual Dues

ASPD
- ☐ Professional $10.00

JPD
- ☐ Professional 5.00

NADE
- ☐ Professional 10.00

NARI
- ☐ Professional 5.00

NARS
- ☐ Professional 5.00

NCRHIP
- ☐ Professional 5.00

NRCA
- ☐ Professional* 15.00
- ☐ Member 15.00
- ☐ Student 6.00
- ☐ Affiliate 6.00

**Please attach evidence of educational attainment (transcript or copy of graduate degree).*

VEWAA
- ☐ Professional 10.00
- ☐ Associate 10.00
- ☐ Student 5.00

Please make checks payable to National Rehabilitation Association

TOTAL $_____

Chapter desired if other than area in which you reside:

_____

Recruited by:

_____

STUDENTS

I HEREBY CERTIFY THAT I AM A FULL-TIME COLLEGE OR UNIVERSITY STUDENT

_____
SIGNATURE OF STUDENT MEMBER

Division Members Must Be Members of NRA

Exceptions:

- NRA student members may belong to all divisions except NADE.

IF YOU ARE JOINING MORE THAN ONE DIVISION, PLEASE INDICATE TO WHICH DIVISION YOU WISH THE NRA 5% REFUND ISSUED. _____

industry introduces

A new self-propelled vehicle and upper-torso developer for handicapped children up to age seven, is now available from TheraPlay Products, St. Louis, Missouri.

Called the Halpern Wheeler, the free-wheeling unit can substitute for costly and cumbersome wheelchairs while giving disabled users easy maneuvering control. The multi-directional wheeler is moved by two-handed operation of both 8″ wheels. A single, non-marring caster supports its forward end.

The Halpern Wheeler can also advance rehabilitative training by engaging the child's coordinative and muscular skills. In addition to offering autonomous movement, the vehicle can be used in free play and supervised games.

Developed by a leading physical therapist, the unit is molded from super-strong ABS plastic and is fitted with vinyl-covered mats. The wheeler is easily cleaned with a cloth and is fitted with an adjustable safety belt. Overall size of the stable, ground-hugging unit is 28″ × 13″ × 10″.

For additional information, contact: TheraPlay Products, 29-24 40th Avenue, Long Island City, N.Y. 11101.

Handicapped drivers are frequently unable to return to the driver's seat of their car . . . due to too close parking of an adjacent car.

To help solve this frustrating problem, a new Parking Clearance sign has been designed which in a dignified way requests other drivers to leave a minimum five-foot clearance between cars. This leaves room for a passageway for the wheelchair to reach the car door.

The new Parking sign hangs inside the car and is securely held in place by the raised car window. It "reads" from the outside.

Made of durable white .020 plastic with a blue imprint which includes the important message and the SYMBOL OF ACCESS, the sign is offered at a price of $3.50 each, including prepaid postage. Order Sign Style SA-915 from Seton Name Plate Corporation, 949 Boulevard, New Haven, Connecticut 06505.

Few people realize how often and how skillfully they can be cheated in health related matters. "The Health Robbers"—how to protect your money and your life is a new book which exposes health frauds and quackery of all types. It has 24 chapters, each one written by an expert in his field. The chapters of chiropractic should be of particular interest to physical therapists. All royalties from the sale of "The Health Robbers" will be used to fight quackery. This book can be ordered from George F. Stickley Co., 210 West Washington Square, Philadelphia, Pennsylvania 19106 at $10.50 a copy.

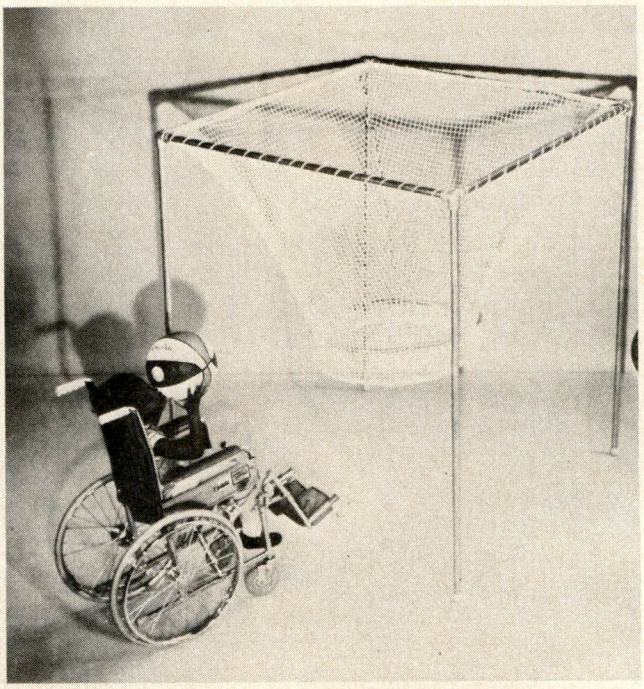
A modified "basketball" game for the severly disabled, non-ambulatory, and young handicapped children, has been developed by TheraPlay Products, Long Island City, N. Y.

Called Successball Jr., the game centers on tossing a standard basketball or lightweight beachball into a drop net suspended from a 4′-square rim standing 5′ high. It is designed to build self confidence at lowest skill levels through virtually-assured successful play.

Successball Jr. units can be used singly in challenge matches by a circle of players, or can be placed at both ends of a "court" for team play on foot or from wheelchairs. Gameplay is both mobile and exciting, offering a full range of developmental activities that are physically, perceptually and emotionally beneficial.

Successball Jr. is rigidly formed from galvanized steel pipe, and is fully portable for indoor/outdoor use. It is extremely stable, disassembles easily for storage, and is supplied with an Instructor's Guide. The unit ships UPS.

For more information, contact: TheraPlay Products, 29-24 40th Avenue, Long Island City, N.Y. 11101.



THE POWER OF POSITIVE REINFORCEMENT: A Handbook of Behavior Modification *by* **Judith Elbert Favell,** *Western Carolina Center, Morganton, North Carolina.* The initial chapters explain preoperational procedures, including the specification and definition of target behavior, measurement techniques and methods of data representation. The remainder of the text details the actual application of behavior modification. Methods for increasing and decreasing specific behaviors through positive and negative reinforcement, token systems, treatment procedures, complex behavior training, and methods of maintaining improved behavior all receive meticulous attention. *'77, 288 pp., 1 il., 1 table, $9.75*

ALCOHOLISM: The Total Treatment Approach (4th Ptg.) *edited by* **Ronald J. Catanzaro,** *Chairman, Research Committee, North American Association of Alcoholism Programs. Foreword by* **Henry W. Brosin.** *(45 Contributors)* For everyone involved in the treatment of alcoholics, this volume gives a concise but comprehensive presentation of this complex disease and of the variety of useful treatment methods available. A group of authorities in the field discuss the total treatment of alcoholism in its three levels of involvement — multidisciplinary, multitherapeutic, and multilocational — as well as family treatment and community education. *'77, 528 pp. (6 3/4 x 9 3/4), 4 il., 23 tables, $22.50*

MEDICAL AND PSYCHOLOGICAL ASPECTS OF DISABILITY (2nd Ptg.) *by* **A. Beatrix Cobb,** *Texas Tech Univ., Lubbock. (23 Contributors)* Written by practitioners in the field who are intimately acquainted with rehabilitation problems, this text integrates and clarifies information relative to diseases of the heart, hemiplegia, strokes, cerebral palsy, amputations, respiratory diseases, diseases of the kidney, disorders of the gastrointestinal system, epilepsy, hearing disorders, visual disabilities, etc. The information is presented in such a way as to develop a medical vocabulary and to describe the interaction of medical factors with the psychosocial components for rehabilitation counselors, nurses and paraprofessional personnel. *'77, 384 pp., 14 il., 11 tables, $13.75*

A HANDBOOK OF MEDICAL, EDUCATIONAL, AND PSYCHOLOGICAL INFORMATION FOR TEACHERS OF PHYSICALLY HANDICAPPED CHILDREN *by* **Harold D. Love** *and* **Joe E. Walthall,** *both of the Univ. of Central Arkansas, Conway.* A superb introduction to the world of the physically handicapped, this book explores such wide-ranging subjects as neuroanatomy; muscles, bones and tendons; psychological testing of orthopedically handicapped children; vocational placement; and architectural barriers in schools. Specific handicapping conditions discussed include cerebral palsy, visual impairment, speech and auditory disorders, and multiple handicaps. *'77, 232 pp., 5 il., 5 tables, $11.75*

PHYSICAL MEDICINE AND REHABILITATION APPROACHES IN SPINAL CORD INJURY *edited by* **John G. Cull,** *Virginia Commonwealth Univ., Fishersville, and* **Richard E. Hardy,** *Virginia Commonwealth Univ., Richmond. (17 Contributors)* An excellent chapter on the urological care of the patient with spinal cord injury is among the features of this interdisciplinary text. The impressive array of contributors also discuss types and effects of spinal cord injury, sexual and vocational implications, the role of regional cord injury centers, and psychotherapeutic concerns. *'77, 336 pp., 52 il., 4 tables, $15.50*

HELP FOR THE HARD-OF-HEARING: A Speech Reading and Auditory Training Manual for Home and Professionally Guided Training *by* **Olaf Haug,** *Baylor College of Medicine, Houston, Texas, and* **Scott Haug,** *Austin Ear, Nose and Throat Clinic, Austin, Texas.* This manual of practical suggestions, directions and lessons will aid the hard-of-hearing individual in adjusting to the hearing aid, in caring for it, and in gaining the maximum amount of speech understanding possible. The book further presents a unique, clinically proven plan for combining speech reading and auditory training into one simple home practice procedure. *'77, 144 pp., 3 tables, cloth-$9.50, paper-$5.95*

THE CHANGING STATUS OF THE BLIND: From Separation to Integration *by* **Berthold Lowenfeld,** *Berkeley, California.* Separation, ward status, self-emancipation and final integration into society are described in this text as four phases in the history of the socioeconomic status of the blind. The current scene of work with the blind, education, rehabilitation, public policy, attitudes, agency system, self-organization, economic forces and public assistance are discussed. The author concludes that, as part of the general fulfillment of the American democratic creed, the blind should achieve full integration as do other minority groups. *'75, 352 pp., 5 tables, $23.50*

CRAFTS FOR THE VERY DISABLED AND HANDICAPPED: For All Ages *by* **Jane G. Kay,** *Tulane Univ., New Orleans, Louisiana.* The projects included in this book are geared for a wide range of clients, from the physically able but very senile to the extremely disabled but mentally alert. The crafts, which are rated on a sliding scale, are inexpensive, utilize safe and readily available materials, and can be completed in one session. Professionals and volunteers alike will appreciate this book, which is unique for its inclusion of explicit instructions and numerous detailed patterns and diagrams. *'77, 224 pp. (8 1/2 x 11), 120 il., $15.50, spiral (vinyl)*

PSYCHIATRIC DRUGS FOR THE NON-MEDICAL MENTAL HEALTH WORKER *by* **William Goldsmith,** *Brentwood V. A. Hospital, Los Angeles.* A basic background in anatomy, physiology, biochemistry and other subjects necessary for an understanding of psychotropic medications is provided in Part I of the volume. Included are sections on neuroanatomy, endocrinology, the heart, the eye and allergy as applied to medication. Part II is devoted to the psychiatric drugs themselves with emphasis on the actions of the drugs, their side affects, and the indications and contraindications for the various drugs. Phenothiazines, antidepressants, lithium, the minor tranquilizers, barbiturates and stimulants are covered in detail. *'77, 188 pp., 27 il., 7 tables, $11.50*

REHABILITATION MEDICINE AND PSYCHIATRY *edited by* **Jack Meislin,** *Albert Einstein College of Medicine, Bronx, New York. Foreword by* **Walter E. Barton.** *(29 Contributors)* The symbiotic and synergistic relationship between psychiatry and rehabilitation medicine are explored in this volume. After defining the terms and identifying the goals of rehabilitation, the authors describe process and methodology. Applications are covered in the sections on mental and geriatric patients and mentally retarded individuals, and in the sections on the various treatment systems. Behavior modification, reality orientation and numerous other techniques are also described. *'76, 564 pp., 1 il., 12 tables, $24.75*

1978 National Conference

Mary E. Switzer Fellowships

Open Papers

Graduate Rehabilitation Literary Awards

Mary E. Switzer Fellowships Announced

The Mary E. Switzer Memorial Committee of the Professional Concerns Commission of the National Rehabilitation Association is pleased to announce that two fellowships will be presented at the NRA Conference in Salt Lake City, September 23–27, 1978.

The fellowships, each in the amount of $2,500, will be given to graduate level students or postdoctoral candidates for study in the area of new methods and techniques in rehabilitation, thus demonstrating their application to the challenges in the field of rehabilitation. The fellowships will be awarded every year, using different topics which will be selected by the Committee.

The candidates must be currently employed in rehabilitation with a minimum of five years experience. The fellowship may be short-term or long-term, but must be completed within the calendar year of 1979. Fellowships will not be awarded for pursuit of academic degree requirements. Upon completion of the program, a monograph will be required which demonstrates the results of the study period.

In order to apply, candidates must submit a statement of their basic philosophy as related to rehabilitation. In addition, a tentative plan concerning the proposed expenditure of the fellowship must accompany the statement. A current resume must also be submitted with employment references, which the Committee may choose to contact. Finalists selected will be asked to present a detailed plan regarding the specific use of the funds. Applications should be submitted by June 1, 1978, to the Mary E. Switzer Memorial Committee, National Rehabilitation Association, 1522 K Street, N.W., Washington, D.C. 20005.

The Mary E. Switzer Memorial Committee was formed in January 1973 as a means of both rendering service to handicapped people and providing a memorial to Mary E. Switzer. Miss Switzer served as Commissioner, Rehabilitation Services Administration from 1950–1967 and Administrator, Social and Rehabilitation Services Administration from 1967–1969. Under her leadership, the state-Federal vocational rehabilitation partnership expanded in terms of both budget and program, and thereby advanced the entire field of rehabilitation.

Open Papers

Once again it is anticipated that the National Conference Planning Committee will recommend the presentation of papers by scholars and practitioners who want to share their knowledge and experience with the field of rehabilitation. A specific time slot, however, has not been determined. Similar to the open papers session program of previous conferences, the 1978 speakers will have the opportunity to present and discuss research findings, demonstration programs, philosophical dissertations, problematic case situations, new techniques and approaches, and other subject matter germane to the rehabilitation of handicapped persons.

Twelve papers will be selected for presentation during this conference period. Using the criteria outlined below, the Editorial Board of the *Journal of Rehabilitation* will review all papers submitted, and select the twelve determined to offer the most balanced contribution to the conference program.

Each speaker will have fifteen minutes to present his/her paper, followed by fifteen minutes for questions and discussion by members of the audience. Thus, each subject will receive a total of thirty minutes consideration. In this way, the ninety minutes available will enable the presentation and discussion of three papers per seminar. Four seminars will be in session simultaneously. To the extent practical, papers concerning subjects closely related to one another will be coordinated for sequential presentation at the same seminar. While it is not possible to guarantee the size of each seminar

NRA Announcements

audience, it is hoped that all seminars will involve audiences that will facilitate satisfactory participation during the discussion periods.

Criteria for Open Paper Seminars. Papers should: **(1)** reflect original and creative thinking; **(2)** exhibit superior quality composition and clarity of expression; **(3)** show sound organization, grammatical correctness, and imaginative style; **(4)** contain new information or proposals that add to the field's body of knowledge; **(5)** constitute a presentation that does not exceed fifteen minutes; **(6)** include an adequate bibliography of reference materials.

In addition to the above criteria, the following requirements apply to participation in the Open Papers Seminar: **(1)** papers must be received at the NRA National Office in typed form, double-spaced, no later than April 30, 1978, **(2)** each presenter must understand and agree that no changes will be permitted in the paper—title or content—after it has been submitted to NRA, without the written approval of the Chairman of the *Journal's* Editorial Board; **(3)** each presenter must agree to provide a minimum of twenty-five copies of his/her paper for distribution to the seminar audience; **(4)** NRA reserves the right, for a period of one year, to publish any of the papers presented at the conference, but this right does not signify any guarantee that every paper will be published.

Any person interested in speaking at these Open Paper Seminars should submit three copies of his/her paper to the Commission on Professional Concerns, National Rehabilitation Association, 1522 K Street, N.W., Washington, D.C. 20005.

Graduate Rehabilitation Literary Awards

Annual cash prizes of $300, $125, and $75 will be awarded to first, second, and third place winners, respectively. There will also be two honorable mention certificates awarded.

Entries will be accepted only from persons who are enrolled in graduate programs at the college level, and who are preparing to work professionally with handicapped persons. The paper must be submitted no later April 30, 1978.

Each entry must be certified as the work of the author by an authorized representative of the department in which courses are being taken, and the author of each entry must certify in writing that his manuscript has not been previously published by or submitted to any publication.

This year the specific topic "The Impact of the 504 Regulations" has been selected. Contributors must address this topic in order for the paper to be acceptable.

Manuscripts will be judged on the basis of originality, accuracy, organization, and clarity of expression.

Entries must not exceed 3,000 words (exclusive of headings, references, cuts, tables, etc.). The total number of words must be noted on the title page. An original and two carbon copies must be submitted. Manuscripts must be typed double-spaced on $8\frac{1}{2}'' \times 11''$ paper.

All entries must be submitted to the Graduate Rehabilitation Literary Awards Committee, National Rehabilitation Association, 1522 K Street, N.W., Washington, D.C. 20005.

The National Rehabilitation Association will have the exclusive right for a period of 12 months to publish any papers entered in the contest. Award-winning entries will be given a high priority for publication, but publication cannot be guaranteed. In addition, the editor of the National Rehabilitation Association reserves the right to edit all manuscripts to be published.

Awards will be administered by the Graduate Rehabilitation Literary Awards Committee. Decisions of the committee will be final. If, in the judgment of the committee, entries in a given year are not suitable for awards, the National Rehabilitation Association reserves the right to make no awards that year.

The National Rehabilitation Association's National Awards Program

NRA National Awards have been established to recognize and honor persons and organizations that have made a major contribution to the rehabilitation of handicapped people, or in some significant way contributed to their well-being. In any year the Association may confer six national awards.

The six national awards are: (1) the W. F. Faulkes Award—for technical or professional achievement; (2) the President's Award—for outstanding achievement of a nontechnical nature; (3) the Bell Greve Memorial Award—for creative service to handicapped people and stimulation of public concern for their rehabilitation; (4) the NRA Organizational Award—to be presented to a national organization with an outstanding record of service to handicapped individuals; (5) the NRA Meritorious Service Award—for years of faithful service to the Association and/or for providing services, directly or indirectly to thousands of handicapped persons; and (6) the E. B. Whitten Silver Medallion—for leadership in removing environmental and legal barriers.

Nomination procedure

1) NRA regional organizations, state and local chapters, and individual members are encouraged to present nominations of persons or organizations for national awards. Nominations shall be made on special forms provided by the national office for this purpose. The completed forms should be returned to the national office, which will acknowledge receipt and forward them to the Commission on Professional Concerns which is responsible for making awards recommendations to the NRA Board of Directors.

2) All nominations must be approved by your NRA chapter and a letter of recommendation must accompany the nomination form at time of submission to the NRA national office.

3) Nominations with their accompanying documents will be carefully checked and studied by the proper commission, whose decisions are subject to approval by the NRA Board of Directors. The commission shall make full use of the information obtained both from the local chapters and from selected individuals in making its final selections and recommendations to the Board for awards to be given in any year. Considerable time may elapse, therefore, between commission receipt of a nomination and its final disposition.

4) All nominations will be valid for a one-year period only.

5) Awards will be presented at times and places determined by the Board of Directors, usually at the National Conference. Awards are in the form of plaques, suitably engraved.

6) Persons or organizations nominated for NRA Awards need not be members of the Association.

7) All nominators submitting nominations to be considered for an award to be conferred at the time of the National Conference must submit fifteen (15) copies of the nomination form, chapter letter of recommendation, and other accompanying documents to the NRA National Office by April 30, 1978.

Detailed information on the nature and criteria for the awards is provided herewith. Please read this material carefully before completing the nomination form.

Criteria for Awards

The W. F. Faulkes Award

This is a national award for technical and/or professional achievement in the field of rehabilitation. It was established in 1954 in the name of the Association's founder and first president. This award may be presented to a person or organization that has in the preceding years made a major contribution of national importance to the increase of

knowledge in the field of rehabilitation or to the development of techniques or methods in the application of such knowledge or to the prevention of disability.

Eligibility for this award would be, for example, (a) the author of a notable technical treatise on rehabilitation, (b) a physician or medical school that has discovered a new technique useful in rehabilitating certain groups of handicapped people, (c) a research scientist or laboratory whose work has led to the discovery of a preventive or cure for a handicapping condition, (d) a rehabilitation worker who has put into practice a new rehabilitation technique or method which has had, nationally, an important effect on rehabilitation practice.

The President's Award

This is a national award for outstanding achievement in behalf of handicapped persons. It is presented to an individual or an organization whose activity in the preceding years has made a major contribution to the rehabilitation of handicapped people on a nationwide basis, in an area not generally considered technical.

Eligibility for this award would be (a) a member of Congress who has demonstrated a leadership role in the development and/or passage of legislation which increases rehabilitation opportunities for handicapped people, (b) an employer whose intelligent and persistent efforts provide employment opportunities for handicapped persons and inspire others to do likewise, (c) a member of a profession or other group whose zeal for rehabilitation has heightened the interest and enlarged the contribution of that profession or group, (d) a handicapped person whose example or whose concern for handicapped people has so inspired others as to effect a nationwide impact upon rehabilitation.

The Bell Greve Memorial Award

This is a national award established by the Ohio Chapter of NRA and administered by the National Rehabilitation Association. It may be presented to a person who, like the dedicated worker whose memory it honors, has, shown unusual initiative or creativeness in the development and/or administration of a service program of demonstrated value for handicapped persons. The program concerned must have contributed to an increased public awareness of the problems of handicapped people.

Eligible for this award would be (a) the administrator of a rehabilitation or closely allied program, (b) the director of a workshop or other rehabilitation facility, (c) a research worker, caseworker or supervisor whose efforts have largely been responsible for the development of a new or original program of services, (d) any person in a program or facility that has significantly participated in its development in heretofore untried areas, although not personally involved in direct services to individuals.

The Organizational Award

The Organizational Award is presented to an organization with an outstanding record of service to handicapped individuals. The organization may be one whose principle objectives are in the rehabilitation field or one which, regardless of its major objectives, has demonstrated effective concern for the care, treatment, education or rehabilitation of handicapped individuals.

Eligible for this award would be organizations that have made a contribution to the well-being or rehabilitation of handicapped people in activities over and beyond the purpose for which the organization was established. Nominees eligible for the Organizational Award would be: (a) an organization that has established a unique service program to better serve handicapped people, (b) an organization that has, through its initiative and creativity, developed programs which have contributed significantly to the rehabilitation movement on a national basis, and, (c) organizations that have acted as a catalyst in the community to better integrate, coordinate and develop services to handicapped people.

The recipient of an Organizational Award may be nominated for its past or present program of activities and for its contribution during the preceding year or for a major contribution in preceding years.

The National Rehabilitation Association Meritorious Service Award

This national award is to be given to an individual who has demonstrated years of faithful service and leadership to NRA through any segment or combination of segments of Association activities or life. Emphasis is placed on both the length of service and levels of service, and is to be given to persons only showing outstanding service or leadership, both qualitatively and quantitatively. It might be given to a member who has provided outstanding membership effort and leadership for a period of ten to fifteen years, or for example, a member who has been exceedingly active in chapter, division and/or national committee(s) effort(s) and has demonstrated leadership for a similar period of time. Sustained membership in the Association is required.

Also, the award may be given to a member who has demonstrated a lifetime or near life of service to handicapped people of a substantial number. Such services, however, while affecting large numbers of handicapped persons, need not necessarily be national in geographic scope but must be very substantial in number. The services may be of a direct or indirect nature. Outstanding clinicians and administrators and other persons within the rehabilitation movement, broadly defined, are eligible for this award.

The E. B. Whitten Silver Medallion Award

This is a national award established in 1974 in honor of NRA's first executive director. It is to be presented to individuals who have contributed to the achievement of the new purpose of the Association which was adopted by the Delegate Assembly in 1973.

Criteria for the award is as follows: the Silver Medallion, established in honor of E. B. Whitten, NRA director for more than twenty-five years, will be presented to an individual who has exercised notable leadership in removing environmental and legal barriers and in overcoming discrimination which keep handicapped individuals from living normal lives and enjoying the rights and benefits due every American citizen. The contribution of the individual may have been made nationally or locally but, if made locally, must have been of such nature as to influence action on a regional or national basis.

National Rehabilitation Association Nomination Form for Awards Program

I. _____
(name of nominee)

_____

_____

_____
(address of nominee)

II. The above nominee is being nominated for the _____ award to be presented by NRA. (NRA Awards include the W. F. Faulkes Award; the President's Award; the Bell Greve Memorial Award, the Organizational Award; the NRA Meritorious Service Award; and the E. B. Whitten Silver Medallion).

III. List of colleges or universities attended and degrees earned (if applicable).

_____

_____

_____

IV. List positions previously held, including length of term. *Underline* positions which have special bearing on the appropriateness of the proposed honor.

_____ current position

_____

_____

_____

V. List honors, citations, or other forms of recognition accorded the nominee that bear on his contribution to the disabled and their rehabilitation.

_____

_____

_____

_____

VI. List affiliations and/or activities of the nominee which may be helpful in the evaluation process.

_____

_____

_____

_____

VII. On a separate sheet, *narrative form*, state why you believe this individual or organization should receive an NRA Award. Your statement may be as long as you wish, and you may add explanatory or corroborating statements from other individuals or organizations. Statements should be specific as to the nature, scope, and importance of the contribution made by the nominee to the rehabilitation of the handicapped or to their well-being. All statements should be signed. (Note: EMPHASIS ON THE NATIONAL SCOPE OF CONTRIBUTION IS PARTICULARLY IMPORTANT.)

VIII. _____
(name of nominator)

_____
(position held)

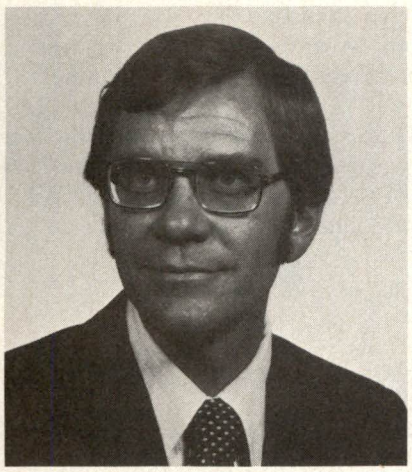
_____
(address of nominator)

_____
(date nomination submitted)

NOTE: Fifteen (15) copies of all nomination forms with appropriate supporting data should be forwarded by April 30, 1978 to the following:

Commission on Professional Concerns
National Rehabilitation Association
1522 K Street, N.W.
Washington, D.C. 20005

1978 NRA OFFICERS



Carl E. Hansen, Ed.D.
NRA President

Dr. Hansen has been a rehabilitation counselor in the states of California and Colorado and is currently a rehabilitation counselor educator serving as director of rehabilitation training at the University of Texas at Austin, where he has been for the past nine years. Dr. Hansen received his doctorate in rehabilitation counseling from the University of Northern Colorado. A great deal of Dr. Hansen's contribution to the field of rehabilitation has been in literature, as he has published over 30 articles dealing with rehabilitation. Dr. Hansen served as NRA Treasurer, President of NRCA, and coeditor of the *Journal of Applied Rehabilitation Counseling.* He has served as Vice-President of the Texas Rehabilitation Association and has assumed a number of committee assignments within the state chapter during the last nine years that he has been a Texas resident. Dr. Hansen voluntarily serves on numerous boards and advisory committees in the Austin area.

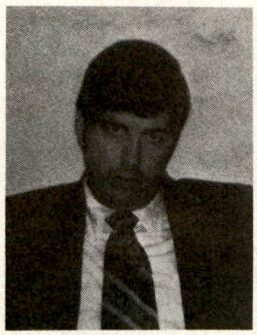
Elizabeth H. Anderson
NRA President-elect

Mrs. Anderson is a consultant in rehabilitation and management, and adjunct professor at Queensborough Community College in New York. She previously served as Chief of Rehabilitation and Executive Assistant to the Director of Creedmore Psychiatric Center, where she created the first rehabilitation center to be established in a psychiatric center. She is an honor graduate of Hunter College in New York City. Mrs. Anderson has been active in NRA for many years, serving as regional representative, board member-at-large, chairperson of the Fiscal Committee, member of the Executive Committee, and most recently NRA Treasurer. Founder of the American Day Care Coalition in NYC, she also was the regional rehabilitation planning director for the New York State Board of Regents.

I. W. (Bill) Leggett
NRA Treasurer

Mr. Leggett is the assistant director, field services division of vocational rehabilitation in Jackson, Mississippi. He has spent twenty years in the vocational rehabilitation field. Mr. Leggett has received numerous awards for his outstanding leadership. Among them is the Award for Meritorious Service, presented him by the National Rehabilitation Association Board of Directors in 1974. Mr. Leggett is a life member of NRA and is a member of its Board of Directors. He has served as consultant and advisor in the development of various branches of NRA, and served as past president of state, regional, and national Rehabilitation Counseling Associations. Among his many other activities, Mr. Leggett is a member of the Mississippi Governor's Manpower Council and the Jackson, Mississippi Mayor's Manpower Council.

new board members



James B. Adams
Southeast Region Representative

Mr. Adams has been employed by the Kentucky Bureau of Rehabilitation Services in the Paducah, Ky. office since 1968. He has been the area supervisor for western Kentucky since 1972, and before that was a general counselor. Prior to his rehabilitation work, Mr. Adams was a high school teacher and continues to teach courses in Rehabilitation Counseling at Murray State University, Murray, Ky., on a part-time basis.

Mr. Adams served as President of the Kentucky Rehabilitation Association in 1974–1975, and was Secretary-Treasurer of the Southeast Region this past year. He has also served on many different state and regional committees. In addition to being a life member of NRA, Mr. Adams is a member of ASPD and the National Education Association, and is a Certified Rehabilitaton Counselor.

Bill Bain
Southwest Region Representative

Mr. Bain is the Director of Rehabilitation Services, Elkins Institute, Dallas, Texas, and is serving in his third term as mayor of Lancaster, Tex.

Mr. Bain was finance director and money raiser for the annual conference of the Texas Rehabilitation Association and served as its president in 1976.

In 1976 Mr. Bain accepted a position on the NRA National Membership Commission, and in July 1977 became chairman. His main objective as chairman has been not only to increase membership, but also to help chapters, states, and regions share ideas about successful means of increasing membership.

Fred C. Board
Division-elected
Job Placement Division

Mr. Board is Executive Director of Just One Break, Inc., and has assisted in the formation of similar organizations in the United States and Canada. In addition, Mr. Board is a consultant and lecturer to New York University, Columbia University, Hunter College, Long Island University, and the National Rehabilitation Counseling Division of the NRA.

Among many rehabilitation activities, Mr. Board has served as Project Director for several studies for the Vocational Rehabilitation Administration. He is also a member of the President's Committee on Employment of the Handicapped. Mr. Board is a past national president of the JPD.

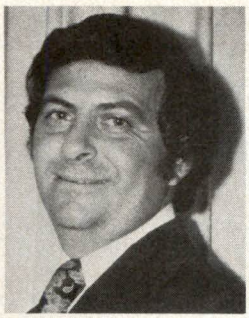
Lewis Buckingham
Division-elected
National Association of Disability Examiners

Mr. Buckingham worked for fourteen years as a Service Officer for Veterans Organizations in North Carolina, Pennsylvania, Virginia, Texas, and the District of Columbia.

Mr. Buckingham was the examiner when first appointed to the Disability Determination Division of the D.C. government in 1961. Upon Mr. Buckingham's retirement from the D.C. State agency in 1973, he served as NADE representative at NRA headquarters. He processed both the incorporation and Internal Revenue exemption for NADE and NARS.

Mr. Buckingham has served as NADE Secretary-Treasurer and NADE President. He was elected by the NADE Board in June 1977 to the NRA Board, replacing its representative who had resigned. Mr. Buckingham was elected by the NADE Delegate Assembly in September to complete the unfinished term on the NRA Board.

new board members



William M. Burnside
NRA Board Member-at-Large

Mr. Burnside is Regional Director of the Virginia Department of Vocational Rehabilitation (DVR) located in Springfield, Va. He was previously employed as a rehabilitation counselor with the DVR in the Fredericksburg field office.

Mr. Burnside was membership chairman for the Mid-Atlantic Region (1975–1976). He served on the Board of Directors (1970–1974) and was president (1974–1975) of the Virginia Rehabilitation Association. Mr. Burnside is now serving as Mid-Atlantic Regional Representative for the Council of Chapter Presidents.

Margie Staton Sloan
Council-elected
Council of Consumer Members

Mrs. Sloan is currently a Regional Program Specialist for the Rehabilitation Services Administration. She works with all aspects of the Vocational Rehabilitation program with special emphasis on architectural barriers; Section 504 of the Rehabilitation Act of 1973; coordination of regional training programs; private, non-profit rehabilitation agencies; and consumer groups. Mrs. Sloan previously was the Executive Secretary of the Governor's Commission on the White House Conference on Handicapped Individuals (Georgia). Other activities include Vice President, 1976–1977, Georgia Rehabilitation Association and Ms. Wheelchair America, 1978.

Mrs. Sloan received her M.Ed. Degree in vocational rehabilitation counseling from Georgia State University in 1974.

Judy Spolum, CRC
Council-elected
Council of Chapter Presidents

Mrs. Spolum is presently the Training Director for Research and Training Center 10, Department of Physical Medicine and Rehabilitation at the University of Colorado Medical Center in Denver, Colorado. She has previously worked as a rehabilitation counselor with both a general and psychiatric caseload and as the Director of the Rehabilitation Services Clinic at a general hospital. She received her B.A. in the Social Sciences and M.A. in Rehabilitation Counseling at Michigan State University.

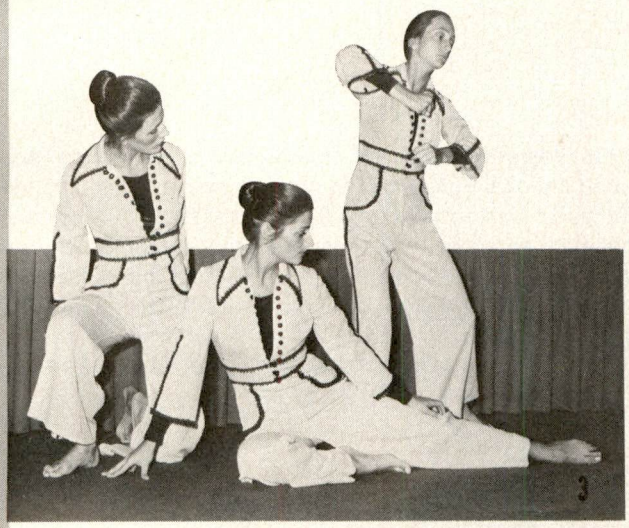
Mrs. Spolum's other responsibilities this year will include the Membership Commission and ASPD of which she is Vice President. Prior activities with NRA involve a number of local, regional, and national offices including President of the Colorado Rehabilitation Association.

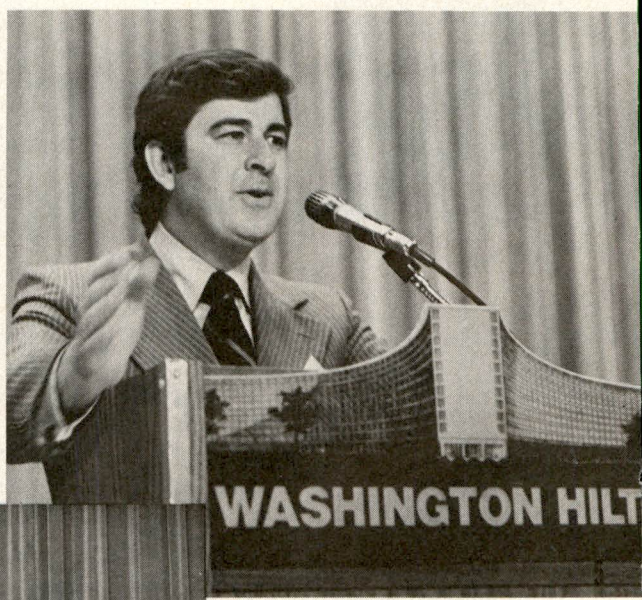
Lucille Zuber
Division-elected
National Association of Rehabilitation Secretaries

Mrs. Zuber is secretary to the Director of the Vocational Rehabilitation Division of the State Education Department, Santa Fe, New Mexico.

She has been a delegate to NRA annual meetings since 1974. Mrs. Zuber has served as secretary of NARS, as a member of the NARS board, the NRA National Conference Committee, and the New Mexico Rehabilitation Association Board. Mrs. Zuber has been membership chairperson for both the New Mexico Rehabilitation Association and the New Mexico Association of Rehabilitation Secretaries which she helped organize in 1972.

1977 NRA NATIONAL CONFERENCE





September 6-10, 1977

"Together We Build" was the theme of the September 1977 National Rehabilitation Association's National Conference, held in Washington, D.C., and the meshing of panel discussions, speeches, and workshops extended that theme into a stimulating arena for the exchange of goals and ideas.

More than 1,700 conferees met in the Washington Hilton Hotel and heard the thinking of both political figures and professionals representing the sciences, several of whose speeches are featured in this issue, on the subject of rehabilitation and all it encompasses.

NRA President Cornelius L. Williams presided over the Opening Session which was highlighted by performances of the U.S. Armed Forces Honor Guard and Band and the Gallaudet Dancers of Gallaudet College, Washington, D.C. Walter E. Washington, Mayor of the District of Columbia, welcomed NRA members, and Dr. Edwin W. Martin, Deputy Commissioner for Education of the Handicapped, Department of Health, Education, and Welfare, was the featured speaker.

NRA's General Session featured E. B. Whitten, Consultant to the NRA Board, and Dr. Ruth V. Washington, Chairperson, Benefits Review Board of the Department of Labor. They discussed the implications of Sections 503 and 504 Regulations with the group. The Third General Session, "The Role of Rehabilitation Engineering in Service Delivery," introduced as speaker, Dr. Larry Scadden of the San Francisco Rehabilitation Engineering Center.

Thursday the NRA Congressional Breakfast, sponsored by the NRA Council of Chapter Presidents, brought the NRA members from across the country in contact with their Senators and Representatives. Dr. Peter G. Bourne, Special Assistant to President Carter, addressed the overflow crowd.

1 **Dr. Edwin W. Martin, Deputy Commissioner for Education of the Handicapped, Department of Health, Education, and Welfare, is the featured speaker at the Opening Session.**

2 ***Left to right:*** **Cornelius L. Williams, NRA 1977 President, Elizabeth H. Anderson, NRA 1977 Treasurer, Carl E. Hansen, NRA 1977 President-elect, greet guests at 1977 President's Reception.**

3–4 **The Gallaudet Dancers provide entertainment for the Opening Session.**

5 **Dr. Peter G. Bourne, Special Assistant to President Carter, addresses the Congressional Breakfast.**

6 **Cornelius L. Williams, NRA 1977 President, addresses the 1977 Opening Session.**

7 **Guests are greeted at the 1977 President's Reception.**

8 ***Left to right:*** **Vernon E. Hawkins, NRA Board Member, meets with Representative Walter E. Fauntroy, District of Columbia, prior to the Congressional Breakfast.**

Washington Hilton Hotel, Washington, DC.

9

During the Delegate Assembly also held Thursday, Cornelius L. Williams relinquished his duties as NRA President, and turned over the gavel to incoming president, Dr. Carl Hansen, director of rehabilitation training at the University of Texas at Austin. NRA also elected new officers. Elizabeth H. Anderson, New York, New York is president-elect and I. W. (Bill) Leggett, Jackson, Mississippi is treasurer.

The NRA Awards Luncheon was held Friday. A very warm address to the conference by Frank Gentile of the Human Resources Center, Albertson, New York, and the honoring of the award recipients highlighted the luncheon. The tenor singing of Mr. Donald Chestnutt accompanied by Ms. Delores Riley on the piano provided an inspirational note with their selections, "This Little Light O'Mine" and "Soliloquy."

Saturday's conference climax was the appearance of Joseph A. Califano, Jr., Secretary of the Department of Health, Education, and Welfare. He showed a sensitivity to the needs of the disabled, especially as they pertain to the 504 Regulations, and addressed himself to the goals of the Carter administration as they relate to the country's disabled citizens.

NRA held concurrent sessions throughout the conference, discussing professional, economic, and governmental problems facing rehabilitation. Sessions included such speakers as Jack F. Smith of the White House Conference on Handicapped Individuals; topics as "Employer Needs: The Business of Placement"; and Open Paper Sessions.

Divisions of NRA also held luncheons and workshops which were attended in large numbers by conference members. Among the many informative sessions was "Current Trends in Social Security Legislation" sponsored by National Association of Disability Examiners (NADE) and "Rehabilitation in the Private Sector" sponsored by National Rehabilitation Counseling Association (NRCA).

Once again we had the input of associated organizations such as the Commission on Accreditation of Rehabilitation Facilities (CARF) and the National Council of Rehabilitation Educators (NCRE). They too provided sessions of interest including "An Expanded Comprehensive Model for Rehabilitation Education" sponsored by NCRE, and "The Realities of Consumers and Rehabilitation Facilities" sponsored by CARF.

10

9 *Left to right:* Cornelius L. Williams, NRA 1977 President, Dr. Ruth V. Washington, Elizabeth H. Anderson, NRA 1977 Treasurer, E. B. Whitten, NRA consultant, meet prior to Thursday Session.

10 Elizabeth H. Anderson, NRA 1977 Treasurer, introduces Dr. Ruth V. Washington, Chairperson, Benefits Review Board of the Department of Labor, to the General Session.

11 Dr. Ruth V. Washington addresses the General Session.

12 Richard P. Oestreich, newly appointed NRA Executive Director, addresses Delegate Assembly.

13 Conferees attend Evening at the Kennedy Center, sponsored by the D.C. Rehabilitation Association.

14 Joseph A. Califano, Jr., Secretary, Department of Health, Education, and Welfare, and Cornelius L. Williams, NRA 1977 President at Saturday Session.

15 Secretary Joseph A. Califano, Jr., addresses Saturday Session.

11

12

This year university sessions were inaugurated. Several workshops involved were "Human Sexuality Counseling for Mentally Retarded and/or Multiply Handicapped Clients" sponsored by the Illinois Institute of Technology, ITT Center, Chicago, Illinois, and "Supervisory Selection in Vocational Rehabilitation Agencies" sponsored by the University of Oregon, Eugene, Oregon.

The District of Columbia chapter of NRA was host to the Conference and provided a warm reception throughout the week to all participants. Information and transportation were also furnished by the D.C. chapter as well as a dance on Friday night. An additional chapter plus was the sponsoring of an Evening at Kennedy Center featuring the play, "Do You Turn Somersaults?" starring Mary Martin and Anthony Quayle. A special thanks is extended to the Lincoln Technical Institute which sponsored the reception following the performance in the rooftop Atrium of the Kennedy Center.

As the NRA National Conference came to a close Saturday it was hoped that the words of Cornelius L. Williams, Past President of NRA would hold true—"that we can take from this conference a renewed commitment and information which will help us meet the challenges of the future in behalf of individuals who are handicapped as 'Together We Build'."

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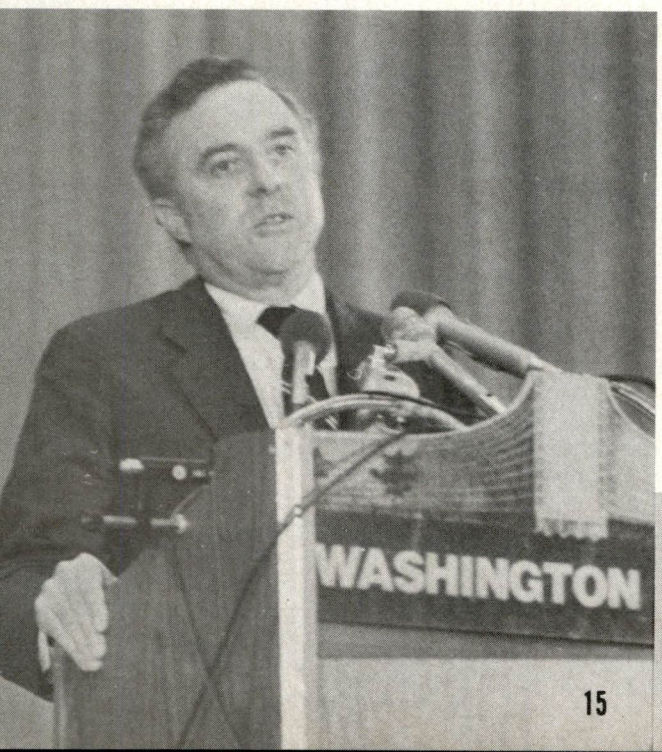

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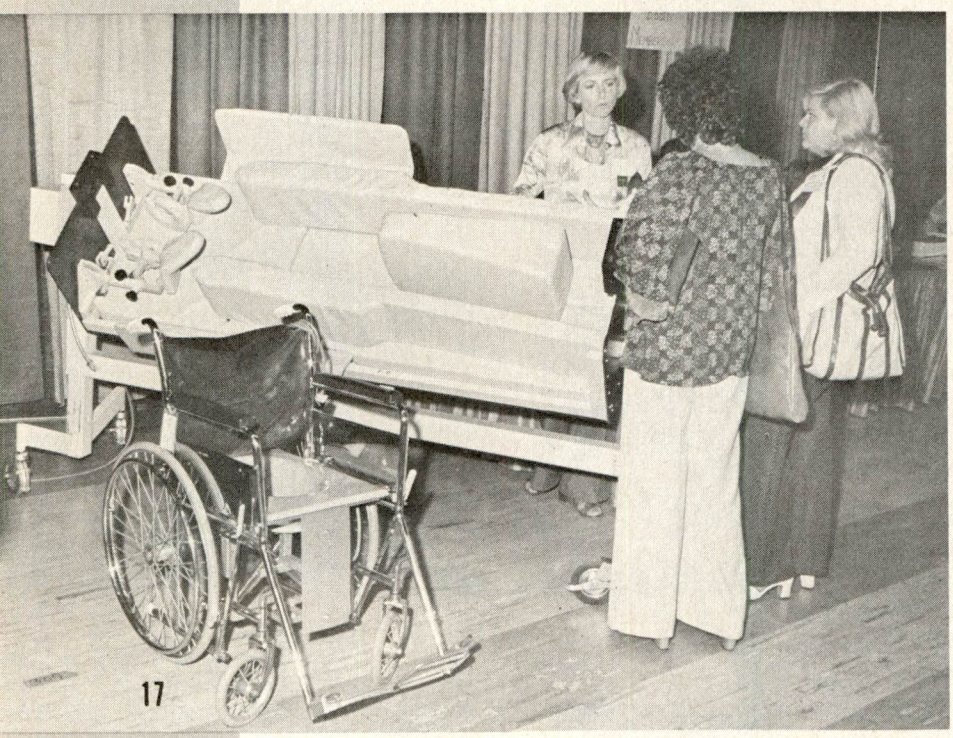


16 NRA members listen attentively to speech of Secretary Joseph A. Califano, Jr.

17 Conference attendees visit one of many exhibits in the Exhibit Area.

18 *Left to right:* Cornelius L. Williams, NRA 1977 President, Vernon Hawkins, NRA Board Member, Carl E. Hansen, NRA 1977 President-elect, and seated, Frank D. Gentile, NRA Awards Luncheon Speaker, meet prior to Luncheon.

19 Mr. E. B. Whitten, former NRA Executive Director, receives recognition for his service at Awards Luncheon.

1977 National Rehabilitation Association Awards

Organizational Award

The Organizational Award is presented to an organization with an outstanding record of service to handicapped individuals. The organization may be one whose principle objectives are in the rehabilitation field or one which, regardless of its major objectives, has demonstrated effective concern for the care, treatment, education, or rehabilitation of handicapped individuals.

The Elwyn Institute
Elwyn, Pennsylvania

The Elwyn Institute, a voluntary nonprofit organization, has developed some of the most innovative and effective programs for rehabilitation of mentally retarded individuals in this country. It is one of the largest private, residential facilities in the United States, and serves over 2,000 handicapped persons on a daily basis.

Elwyn Institute, in achieving its objectives, has demonstrated deep concern for the care, treatment, and education of handicapped people. It has been a true leader in promoting institutional reforms, community services, and training at both the national and international levels.

Elwyn's pioneering efforts and its contribution to the field of rehabilitation are many and varied: it established the first contract workshop for retarded individuals in a residential setting; it developed the first private trade school for mentally handicapped individuals in a residential setting; it established the first half-way house and the first group home for retarded persons in Pennsylvania; and it developed one of the first deinstitutionalization programs in the United States. Also, Elwyn was an early exponent of the establishment of satellite programs, and pioneered in the development of a comprehensive range of services for handicapped individuals and in the establishment of community services.

The E. B. Whitten Silver Medallion

The E. B. Whitten Silver Medallion Award was established in 1974 in honor of the Association's first Executive Director. The Award is presented to an individual who has exercised notable leadership in removing environmental and legal barriers and in helping to overcome discrimination of handicapped individuals.

Jose Martinez
San Juan, Puerto Rico

Jose Martinez, professor of rehabilitation at the University of Puerto Rico, consultant in rehabilitation, and long-time, bilingual professional has worked in behalf of handicapped people in numerous capacities.

Mr. Martinez has a deep commitment to handicapped people. He served the state-federal program of vocational rehabilitation as State Supervisor and Assistant to the Director of Vocational Rehabilitation of Puerto Rico. His long and distinguished career includes service as the Director of the Governor's Commission for Statewide Planning and as Executive Director of the Narcotic Addiction Control Commission.

Long active in NRA affairs, he was the founder of the Puerto Rico Rehabilitation Association and twice served as its President. He is the recipient of numerous honors and citations and is active in a variety of volunteer activities. He currently serves as President of the Puerto Rico Institute for Retarded Children and is also Vice-President of the Epilepsy Society of Puerto Rico.

Mr. Martinez' record is one of participation and deep involvement in educational activities and in the elimination of obstacles which militate against handicapped people. During his career as a rehabilitation professional, he has worked continuously in removing barriers and in eliminating discrimination of handicapped individuals.

The W. F. Faulkes Award

The W. F. Faulkes Award, established in the name of the Association's founder and first President, is presented for technical or professional achievement in the field of rehabilitation. The recipient must have made major contributions, of national importance, to the increase of knowledge in the field of rehabilitation or to the development of techniques or methods which aid in the prevention or reduction of disability.

Arnold B. Sax, Ed. D.
Menomonie, Wisconsin

Dr. Arnold B. Sax, teacher of mentally retarded individuals, innovator of ideas, catalyst and motivator of people, has had and is continuing to have a distinguished and effective career in rehabilitation. As a concerned and dedicated worker in the field of rehabilitation, he was one of the first to recognize the need for professional guidance and counseling of students

icated service which has resulted in major contributions toward the organizational advancement of NARI.

Michael Nelipovich
Little Rock, Arkansas

In 1975, at the National Rehabilitation Association Conference in Cincinnati, Ohio, Mr. Michael Nelipovich was instrumental in forming the National Association of Rehabilitation Instructors (NARI), and was selected as President. Over the past two years under his leadership, he has produced a division with strength and which rehabilitation instructors can identify with as their professional organization.

Mr. Nelipovich is employed by the University of Arkansas. As an instructor in the Graduate Program in Blind Rehabilitation, his former employer was the State of New Mexico where he worked with the visually impaired.

Mr. Nelipovich received his M.A. from Western Michigan University in Rehabilitation Teaching for the Blind and a B.A. in Sociology from Wayne State University.

He was President of the New Mexico Teachers Association and the New Mexico Chapter of the American Association of Workers for the Blind (AAWB). Mr. Nelipovich has also held several offices and served on many committees both in NRA and AAWB.

National Association of Rehabilitation Secretaries 1977 Service Award

The recipient of the National Association of Rehabilitation Secretaries Service Award must be employed in a rehabilitation setting in a clerical or secretarial position, and must have excelled in performance. The recipient must be recognized by co-workers and supervisors as well as the community for outstanding efforts.

Zane Davis
Oxford, Mississippi

Mrs. Davis has been an employee of the Division of Vocational Rehabilitation since January 1958 and for more than ten years, has functioned as an Area Supervisor's secretary.

She has repeatedly demonstrated her advocacy of handicapped individuals. Through the years, she has been the recipient of many awards and honors for her work with VR and as a voluntary advocate of handicapped individuals.

Mrs. Davis has worked with city planners in Oxford, Mississippi, attempting to get a program underway to eliminate architectural barriers on the city square and in public buildings. In this endeavor, she has demonstrated executive ability for impressing upon the governing body of this city the need for such actions by making these persons aware of how difficult architectural barriers would be should they find themselves on crutches or in a wheelchair.

Physically impaired by the residuals of polio at an early age Mrs. Davis was a VR client, thus has first-hand knowledge of what it means to be vocationally rehabilitated. She has a compassion for the disabled, which combined with her capability, her ability to influence others to give of their best, her knowledge of VR regulations and policy, her great devotion to the cause of rehabilitation, makes her a shining, outstanding example of what vocational rehabilitation is all about.

National Rehabilitation Counseling Association Elkins Counselor-of-the-Year Award

The Elkins Counselor-of-the-Year Award is presented by the National Rehabilitation Counseling Association in recognition of a devoted, professional rehabilitation counselor whose efforts far exceed required standard performance, and whose accomplishments are recognized by the recipient's peers, supervisors, and community.

Jeff Graham
Alpine, Texas

Jeff Graham has spent the last 15 years as a counselor for the Alpine office of the Texas Rehabilitation Commission, a geographic area generally regarded as the most remote in the state. Mr. Graham has established himself as an innovator in rehabilitation counseling, and has succeeded in dealing with the unique problems of working in a sparsely populated area, in which medical and evaluative facilities are both very small and widely dispersed.

Mr. Graham received his B.A. (Spanish), M.Ed. (Counseling and Guidance), and M.B.A. (Economics) degrees from Sul Ross State University, and is a Certified Rehabilitation Counselor.

Vocational Evaluation and Work Adjustment Association's Paul R. Hoffman Award

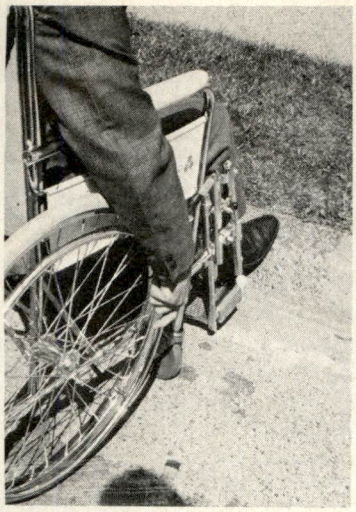
The Paul R. Hoffman Award is bestowed upon an individual for professional achievement in the field of vocational evaluation and/or work adjustment by the National Vocational Evaluation and Work Adjustment Association. It was established in 1974 in the name of the Association's first president, Paul R. Hoffman. The Award is presented to a person who has made a major contribution, signifying unusual initiative and creativity, to the rehabilitation of handicapped citizens through more effective utilization or creation of vocational evaluation and/or work adjustment techniques.

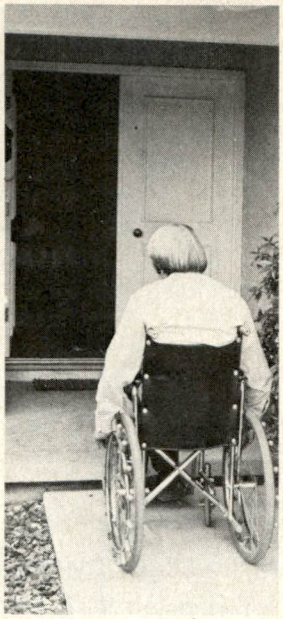
Thomas W. Gannaway
Rochester, New York

Mr. Thomas Gannaway is the Director of Research and Development for the Singer Careers Systems, Rochester, New York.

He has been a very active member of VEWAA since he began his career in rehabilitation as a Vocational Evaluator at the Yarborough Rehabilitation Center in Milledgeville, Ga. Mr. Gannaway has worked hard for the initiation of VEWAA forms throughout the southeastern region, developing training materials for VEWAA members, identifying and organizing state chapters throughout the country, organizing the first regional chapter of VEWAA, and modification and distribution of the association's by-laws. He has served in elective offices both at the state and regional levels and has served on various committees at the national level.

In conjunction with his existing job, Mr. Gannaway has responsibility for the research and development of evaluation and adjustment programs to be used in the field of rehabilitation. He has visited hundreds of rehabilitation facilities in his efforts to up-grade evaluation adjustment services techniques. While his job makes no demand that he be active in VEWAA, Mr. Gannaway has continued to devote time to its development and improvement.





getting unstuck

Frank D. Gentile

The following is the speech given by Frank D. Gentile before the NRA Awards Luncheon, NRA National Conference, September 9, 1977, at the Washington Hilton Hotel, Washington, D.C.

I am honored and pleased that you have asked me to share in this program which I know is an important moment in the lives of the award recipients.

Rehabilitation has come a long way. I can remember the days when I was *really* handicapped, being carried up and down stairs of concert halls and airplanes, and with few or no accessible bathrooms. Life was difficult and discouraging.

Today I can get around with more ease of accessibility: onto airplanes, into hotels, motels, restaurants and—most important—restrooms.

However, my problems—or I should say situations—are more complex. They are the subtle attitudes of those around me. When I go to an airline counter or restaurant—while they are willing to serve me, I find that I am not the one with the "power." It's anybody who is with me that looks "normal." The reservation clerk or maitre d' asks the other person, "can he walk," or "would he like a regular chair," or "what would he like." However, *I* always get stuck with the check! The international symbol abounds, and while "they" recognize that "I' have rights, many people are uncertain about what to do about me or my disabled fellow Americans.

Rehabilitation has entered a new stage, one that is at once more hopeful and more difficult, more important and more painful. It is the effort to build on newly won human rights for the disabled and give them substance—in the face of prejudice, negative attitudes and beliefs of the past. In order to move forward we must find ways to get unstuck, think creatively and *do*. In accomplishing this, the survival of any particular method, belief, or technique is unimportant.

It was only in the last century that many outstanding people believed that there was little left to do in creating new horizons: in 1875, the director of the U.S. patent office sent in his resignation. There was, he said, "nothing more left to invent." In 1887, Berthollet the great chemist wrote, "from now on there is no mystery about the universe." Lavoisier "proved" that meteorites did not exist. He said, "It is impossible for stones to fall from the sky because there are no stones in the sky."

There is no question which does not require *new* thinking, the willingness to dare. The recipients of the awards at this NRA conference have demonstrated this ability—to get unstuck, change, and do.

I believe we need to begin anew the unceasing search for new horizons of science, technology, personal relations, and freedom. To meet these challenges we must be imaginative and creative—not blindly wed to yesterday.

One part of this search is work—jobs—self-sufficiency and integrity. Human beings need a purpose, and that purpose can be achieved if we further develop a system where there are jobs at decent wages for all who are able to work, and provide adequate assistance in a dignified way for those who are unable to work.

Of the more than 220 million people in U.S., 30 million are disabled in one way or another. Of this number 11,300,000 are potentially employable yet, only 4,100,000 are employed. Of these many are under employed, most below $7,000 per year and many below $2,000 per year.

Of disabled persons of working age who are not in institutions 42% are employed, as compared to 59% of the national population. A difference of 17% or 2,100,000 people. If these persons could be employed at only $5,000 per year it would mean 10 billion, 500 million dollars per year added to the economy—plus what we would save in private and public support. They would be wage earners and tax payers.

Affirmative action and nondiscrimination laws—sections 503 and 504—need closer attention. There are mixed emotions about these new and exciting changes. Consumers feel the laws are not strong enough. Employers say the regulations are confusing and will increase their costs. Unions are concerned about seniority. Professionals have mixed feelings. Many of us are stuck in our beliefs, attitudes and old way of doing things. No legislation can satisfy all the demands and needs of a large group of people. The rehabilitation legislation has created the agreement that something must be done to correct a situation, but it has not aligned us or given us the tools to accomplish it.

An agreement is the way we structure our various relationships. Alignment is an experience with purpose and our taking responsibility. If you and I were in a sinking rowboat with sharks all around and you were bailing and I refused, you would bail harder to save yourself—100%! We don't do this in real life. If we were in agreement or aligned we would both just do it—support each other and gain satisfaction. We have assigned others to bail out the boat—to change the world for

the handicapped—employers are responsible for work, architects for barriers, etc.

Suppose one of you called me in the morning and said, "Frank, my car won't start, can you give me a lift to work?" I can experience this in two ways. I can get out of bed, feel lousy about it, and say "well, she's my friend, I've *got* to do it." Or I can say, "of course I will, because I *want* to do it." I can take the responsibility from a point of view of alignment.

Perhaps we should begin to align ourselves with other specialties and techniques. H.E.W. is reorganizing its programs for the handicapped but what about the other agencies? How can we align ourselves with those departments and programs?

Employers are willing to listen to how to hire the handicapped, but lack the sophisticated techniques in meeting needs. Can we accept the responsibility of involving employers in the vocational rehabilitation process as projects with industry and the industry-labor council of the White House conference have done? Can we rethink placement as a process and not just as the end product? Are we willing to look at homebound employment, postemployment services, career development, underemployment and what happens to disabled people on the job? Are we willing to go beyond placement and perhaps learn how we can assist those still seeking work by learning about work? Can we as rehabilitation specialists take the responsibility for bridging the gap and aligning with special education so that severely disabled youth can find productive and meaningful employment?

How can we seek new ways to harness American technology and engineering so that full advantage is taken of new materials and miniaturization to transform the wheelchair, for example, into a fully functional and practical device rather than a chair with wheels? Can we look at disability categories differently as functional capacities and come from a "Yes!" "Can do" attitude into sufficiency instead of deficiency?" Can we all accept the role as agents for creating in others positive attitudes toward the handicapped in our lives?

Like other minority groups, the disabled bear the major burden of their own progress. They need to take responsibility to play a much greater role.

These are not easy challenges. They require each of us to get unstuck, think creatively, change, take responsibility, align with each other and do. We at the human resources center have tried to accomplish these tasks over the years. Today we have embarked on a project called PREP—Programmatic Research On Employment Preparation of the Handicapped—where we are looking at independent living, career education, attitude change, and placement of the severely handicapped. However, our effort is only one part of the responsibility to creatively seek ways to enable the handicapped to lead lives of dignity and productivity. All of us here can align ourselves to this task.

The founders and great leaders of our country knew that change was essential. In 1824 Thomas Jefferson said, "As new discoveries are made, new truths discovered and opinions changed with the change of circumstances, institutions must advance also, and keep pace with the times."

Nearly 40 years later Abraham Lincoln, in a message to Congress, recognized that new problems demanded new solutions. He said: "The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise to the occasion. As our case is new, so we must think anew and act anew."

We also must change to respond to change. We must rethink all our old ideas and beliefs before they capture and destroy us. For those answers we must look inside ourselves, to our rehabilitation colleagues—other fields of knowledge and to the disabled themselves.

Answers founded on clear and dispassionate thought must be matched to action, rooted to conviction and a passionate desire to reshape rehabilitation. The future will be shaped in the arena of human activity by those willing to commit themselves.

Like other minority groups, the disabled bear the major burden of their own progress. They need to take responsibility to play a much greater role. They have to make their own way, as they are doing. However, we must remember that progress is also made through social, political and economic agreement as well as by individual effort.

Answers founded on clear and dispassionate thought must be matched to action, rooted to conviction and a passionate desire to reshape rehabilitation. The future will be shaped in the arena of human activity by those willing to commit themselves.

Rehabilitation is building a new era. It can be alive with energy, where the freedom to think, love life, and the joy of sharing are not sacrificed to individual greed and conflicting interests, with each group struggling to keep the other in its place.

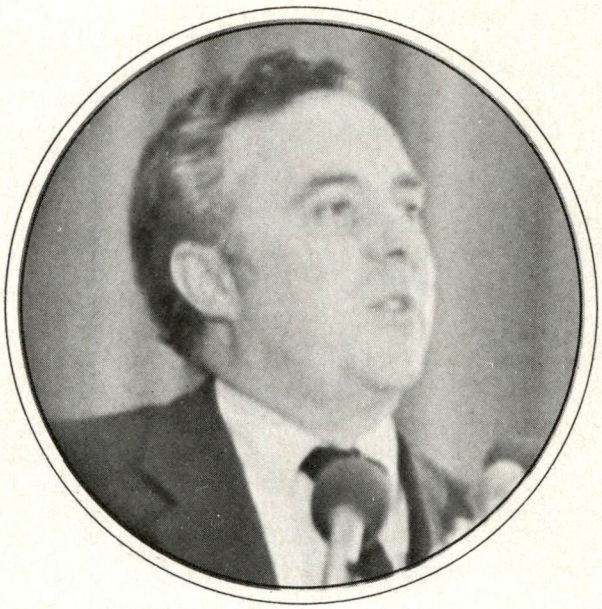
Once a great magician came to perform in a small town. A reward was offered to anyone who could challenge him successfully. Two boys decided to trick him. They agreed to capture a tiny bird which could easily be held in their hands and then, holding their hands behind their backs, to challenge the magician to guess what it was they held behind their backs and in what hand it was held. Then they agreed, if he was successful in his selection, to ask if it were alive or dead. Depending on his answer, they would either crush or free the bird alive. When they stood before the magician he guessed it was a bird and in what hand it was held. Then they said, "Is it alive or dead?" "That," the magician answered, "depends entirely on you."

We can make a new beginning and build. We can do so only if we see now, before it is too late, that what is of importance in each of us is what we share with others and accept. We can build on that feeling—that alignment with each human being—which is the spirit and heart of mankind. And *that* depends entirely on each of you.

Remarks of

Joseph A. Califano, Jr.

Secretary of Health, Education, and Welfare
before the
NRA National Conference
Washington, D.C.
September 10, 1977



I'm glad to be here for several reasons. First, because I welcome a chance to talk to you about some achievements and new directions in a cause that you and I share—the cause of service to handicapped Americans.

Second, because I want to pay a personal tribute to the long record of NRA—to the thousands of professionals and volunteers you represent. It's easy enough to count the years you have been at work. But it's impossible to count the lives you have touched, the barriers you have helped to topple, the programs you have pushed from dream to reality.

Finally, I welcome an opportunity to say a word of admiration, before this audience of her friends, about the woman who is the patron saint of the rehabilitation movement: Mary Switzer. For several years, the building that is headquarters for our rehabilitation services has borne her name. But the real tribute to Mary Switzer is in the lives of hundreds of thousands who have benefited by her example, her inspiration, and her long service to her country.

Like her, you are specialists in the difficult; experts at the impossible. And the human predicaments you face, the handicaps and human tragedies you work to overcome, have been made even more challenging by other difficulties: constricted Federal budgets; a troubled economy; a depressed job market, and the danger that, as we reorganize state and Federal agencies, programs for handicapped citizens may lose their organizational identity.

I have come here today to tell you that I am aware of those difficulties—and that President Carter is aware of them. We know what you and your clients are up against. And we are determined to do all we can to help you achieve our mutual goal: full dignity, full independence, and full participation by handicapped Americans in the life of their nation. We have a long way to go. I was reminded recently of just how far when I heard this story:

A few years ago in Los Angeles, there were earthquake warnings. Most citizens of Los Angeles turned immediately

to their television sets for news bulletins and emergency instructions. But thousands of citizens in Los Angeles are deaf; for them, all these audible bulletins were useless and there were no visual bulletins to help them. Their only choice was to wait for the next edition of a newspaper, which might come too late.

Today, several years after that incident, I am going to announce a step that should make such incidents forever a thing of the past. And in the course of my remarks I want also to discuss briefly and frankly three topics:

- First, some steps that the President and HEW have already taken to serve handicapped Americans;
- Second, some new efforts that are underway in HEW;
- And finally, I want to say a few sober words about the future effectiveness of our rehabilitation programs, in an age of soaring expenses for health and hospital care.

I want to talk, in short, about how far we have come—and how far we have to go.

Steps Taken by President Carter and HEW

Last May President Carter spoke at the first White House Conference on Handicapped Individuals. He declared that day that "the time for discrimination against the handicapped in the United States is over."

The President spoke that day against a background of action already taken. The month before that Conference, I signed a historic document concerning handicapped citizens: the regulations implementing Section 504 of the 1973 Rehabilitation Act.

You know, perhaps better than anyone, how dramatic and far-reaching these regulations are. But I think it's worthwhile to sketch briefly what they will mean—to 35 million handicapped citizens, and to the nation.

We want to help handicapped citizens gain, in the years to come, the same major advances in civil rights and entitlements that women and black citizens have gained in recent years.

These regulations apply to every type of mental and physical disability. They forbid all agencies and institutions receiving HEW funds from discriminating against handicapped citizens—in recruitment, in hiring, in pay, in job assignments, in promotions and fringe benefits.

Furthermore, the regulations are a breakthrough toward accessibility for the handicapped. They require that all new facilities be designed to accommodate disabled and handicapped persons. In existing facilities, they require that all programs and locations be accessible, and if not, that structural changes be undertaken to make them accessible.

For handicapped young people, the regulations are a blow against segregation and other arbitrary barriers. They require that public schools receiving Federal funds must provide an appropriate free schooling to every qualified child, wherever possible, in a normal classroom setting.

In higher education, the regulations require colleges and universities to treat handicapped students equally—in recruitment, in admissions, and in the educational process. Institutions will be required to assure that students are not excluded from programs because auxiliary aids for the handicapped are lacking.

Finally, the regulations apply to health, welfare, and other social services. Henceforth, discrimination against the handicapped in such services is forbidden. Institutions must provide auxiliary aids for the handicapped, including emergency room procedures for communicating with deaf and hearing-impaired people.

These are only a few major provisions. But I think they suggest what gigantic impact these regulations will have on the lives of individuals and of institutions. The changes will be great—but we believe they are worth the effort.

Writing these regulations and signing them is only a beginning. Now we face the enormous job of putting them into effect, and then enforcing them. To that end, we have taken several steps:

- I have directed HEW's Office of Civil Rights to put in place a nationwide technical assistance program to help institutions comply with the regulations.
- We have made several grants under a new project called the HEATH Project—Higher Education and the Handicapped—to help colleges and universities come into compliance.
- We have launched a program to ensure affirmative action, on the part of employers receiving government contracts, to hire handicapped workers.
- And The Architectural and Transportation Barrier Compliance Board, chaired by Assistant Secretary Arabella Martinez, is at work to ensure that Federally-funded facilities will be accessible to handicapped people.

To complete the record, we have taken action on some other fronts. In March I signed another set of regulations—regulations enforcing the 1974 Amendments to the Randolph-Sheppard Act. These require that vending stands operated by blind workers in Federal buildings be given, not just preference of location, but *priority*. In addition, blind persons operating such facilities will gain greater income from vending-machine operations than in the past. Finally, the regulations will establish arbitration procedures for use in determining the location of these vending operations.

This, in brief, is the record of the past seven months. If you take it as an indication that this administration means business about helping handicapped citizens gain full independence, you are exactly right. We want to help handicapped citizens gain, in the years to come, the same major advances in civil rights and entitlements that women and black citizens have gained in recent years.

New Efforts

In our progress toward that goal, we still have a great distance to travel. There is the field of prevention. We need to step up research into birth defects and disabling childhood disease. I was shocked to learn when I took office at HEW that 20 million children under age 15 were without vital immunizations.

There is the economy. We need to improve job opportunities across the board for all citizens—for we realize, in President Kennedy's words, that "a rising tide lifts all ships."

We are not resting on past achievements; we are under-

taking some new efforts. Let me describe three.

The first is a program to help deaf citizens—to guarantee that the Los Angeles story will not be repeated. It is called Closed Captioning for the Deaf.

For several years, our Bureau of Education for the Handicapped has worked with the Public Broadcasting System and WGBH in Boston to bring television to deaf audiences. We made arrangements with WGBH to caption the ABC Evening News, which that network very generously provided. This captioned news was then broadcast later over participating Public Broadcasting Stations. That service is available today on more than a hundred stations nationwide; it is a giant breakthrough in bringing news to deaf persons.

The success of this effort made us eager to extend captioning beyond the news to entertainment and other suitable programs. But commercial broadcasters and advertisers have been concerned that many viewers would reject captioned programs as too visually distracting. For that reason our Bureau of Education for the Handicapped has been supporting research by the National Bureau of Standards and PBS—research to develop a system called "closed captioning." Closed captioning becomes visible only when a special device is attached to the set. This decoder receives a signal sent out by the broadcasters on a portion of the broadcast band called Line 21, authorized for such use by the FCC.

We are now supporting work with Texas Instruments to produce inexpensive decoders, and to perfect a device for use by broadcasters to transmit the captions. The technology is now well enough along that we can envision widespread use of closed caption TV.

Some broadcasters, notably the American Broadcasting Company, have been very supportive of this whole program. Others see continuing obstacles and problems. But the President and I, after reviewing the technological developments, believe that the time has come to move forward.

To that end, I am writing to the presidents of the major television networks, following up on a previous letter from President Carter. I am inviting them to meet with me, along with representatives of government, industry, and organizations of the handicapped, to shape a plan that will clear away the final obstacles and make the decoders available to all who need them. In short, we intend to open the world of television to millions of deaf Americans. That meeting will be held on October 28.

The cost of this program for the networks, when measured against their unprecedented profits, will not be too great; I believe they can afford it. And this fact is inescapable: television today is a chief feature of mainstream life in America. If we are serious about helping handicapped citizens enter the mainstream of American life, we cannot bar them from access to television. I believe that, just as other institutions are facing up anew to the needs and rights of handicapped people, the networks must face up to those needs and rights—and to their obligations in the public interest.

Another new effort underway concerns the recommendations of the White House Conference on Handicapped Individuals. Those recommendations are many; they suggest action, not only by government, but by industry, labor and society in general. We are serious about seeing results from that Conference. I have asked my staff to review the Conference recommendations promptly, and submit a plan for dealing with them. We intend to act; we will not allow the work of that Conference to gather dust until it is forgotten.

The final effort I want to mention is the reorganization, within HEW, of handicapped and rehabilitation services. We have established a new Office of Human Development Services, headed by Assistant Secretary Arabella Martinez. Under this Office will be another new agency: the Administration for Handicapped Individuals.

Under the aegis of the Administration for Handicapped Individuals will be four units: the Rehabilitation Services Administration, the Developmental Disabilities Office, the White House Conference on Handicapped Individuals, and the President's Committee on Mental Retardation.

We have established a new Office of Human Development Services, headed by Assistant Secretary Arabella Martinez. Under this office will be another new agency: the Administration for Handicapped Individuals.

The new Administrator for AHI will also serve as Commissioner of RSA, and I'm delighted to announce the appointment of Robert Humphreys to that post. Mr. Humphreys, who most recently served as Special Counsel to the Senate Committee on Human Resources, is a man of outstanding qualifications and experience, and a friend of the rehabilitation movement.

Our purpose in reorganization is not change for the sake of change: It is to streamline our programs for handicapped persons; to consolidate our efforts in one lead agency, rather than a patchwork of agencies.

Let me assure you, however, that though the organizational charts may change, some things will never change: the high visibility of our handicapped and rehabilitation programs, and the high priority we give them.

The Future

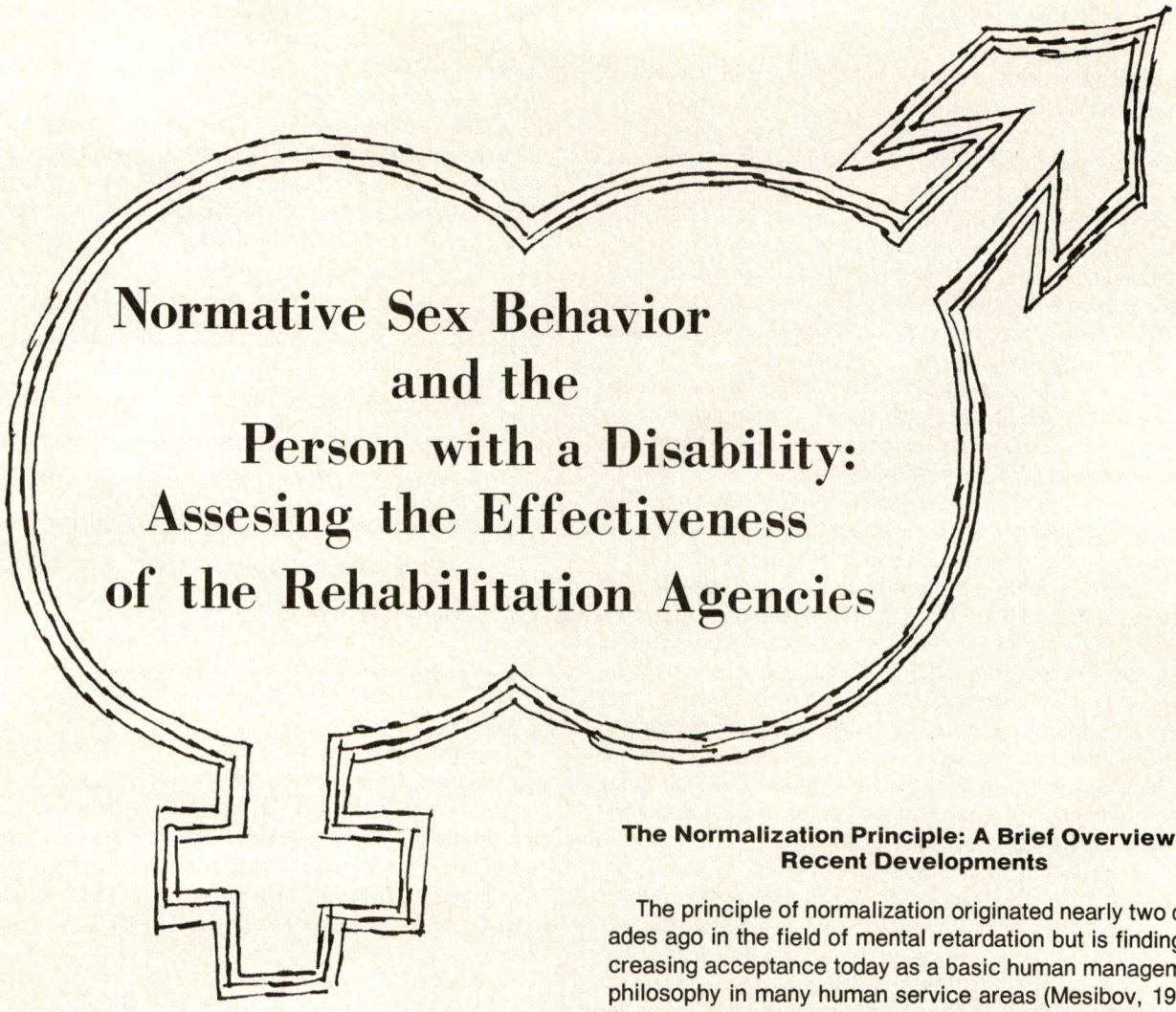
In 1967, our total Public and Private disability expenditures, for income transfers and medical payments, amounted to almost $39 billion. By 1975, only eight years later, those expenditures had grown to $111 billion. The tragedy is that so much of that increase is due to inflation—particularly hospital cost inflation.

The figures are staggering, as you well know. Every single day, hospital costs inflate by $24 million. If Americans receive exactly the same amount of care today that they received yesterday, they will pay $24 million more for it today.

So I urge your support for our efforts to contain these costs—in the interest of the handicapped citizens you represent, and in the interest of all citizens. That is one more way that you can work with your government to ensure a decent quality of life for all.

Reinhold Neibuhr observed years ago that governments cannot love, but they *can* be just. That is our goal: a government that is compassionate and just. With your help, we will achieve it—for handicapped citizens, and for all citizens.

Thank you.



Normative Sex Behavior and the Person with a Disability: Assesing the Effectiveness of the Rehabilitation Agencies

Robert J. Flynn
Ami Sha'Ked

This paper has several purposes: to discuss several major habilitative implications of normalization principles, with particular reference to the socio-sexual development of persons with disabling and other deviancy-producing conditions; to present some preliminary findings on the success with which human service agencies, including rehabilitation, are currently fostering normative socio-sexual behavior in their clients; and to suggest a number of ways in which agency services may be optimized in this regard.

The Normalization Principle: A Brief Overview of Recent Developments

The principle of normalization originated nearly two decades ago in the field of mental retardation but is finding increasing acceptance today as a basic human management philosophy in many human service areas (Mesibov, 1976). The principle was first formulated by Bank-Mikklesen, head of the Danish Mental Retardation Services, who defined it as "letting the mentally retarded obtain an existence as close to the normal as possible" (Wolfensberger, 1972, p. 27). Due largely to the efforts of Bank-Mikklesen normalization was written into the 1959 Danish law governing services to retarded persons.

A decade later Nirje (1969) furnished the first systematic statement of the normalization principle in the literature. Nirje, at that time executive-director of the Swedish Association for Retarded Children, defined normalization as "making available to the mentally retarded patterns and conditions of the mainstream of society" (Nirje, 1969, p. 181). In 1968 new Swedish legislation governing services to the mentally retarded was adopted, with normalization as its cornerstone.

Wolfensberger in 1972 universalized the applicability of the principle beyond both mental retardation and Scandinavian culture by defining it in such a way as to be relevant to human management in general, and in any culture. Wolfensberger's definition (1972, p. 28) of normalization has come to be the most widely known and accepted one: "Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible". Stated in these terms, normalization implies a social philosophy from which human service agencies enable and encourage clients to acquire the behaviors, competencies, and appearances considered by a given culture to be typical and valued for persons of similar characteristics—particularly age and sex.

Ultimately, normalization and integration are meaningful only if they culminate in social interaction and social acceptance.

Physical and Social Integration as Major Corollaries of Normalization

It is apparent from the foregoing that normalization is a service philosophy which is aimed at both minimizing deviancy (deviancy-unmaking) and integrating of the deviant person into the cultural mainstream. Ultimately, normalization and integration are meaningful only if they culminate in social interaction and social acceptance.

Physical integration of the disabled and/or deviant person is a necessary, though not sufficient, condition of social integration. Physical integration is attainable in several ways: (1) by locating service programs in the community (rather than in segregated) settings to permit the deviant person to be assimilated by normative educational, vocational, recreational, and other social systems; (2) by situating service facilities in physical contexts appropriate to the type of program in question (e. g., group homes in residential areas, vocational centers in industrial parks, educational programs in schools and colleges, etc.); (3) by ensuring that services are highly accessible; and, (4) finally, by making service facilities relatively small in size and by dispersing them throughout a town, city, or region, such that diviant persons are not congregated in numbers larger than surrounding community social systems can absorb and integrate (Wolfensberger, 1972).

Once physical integration has been attained, social integration can be pursued in several major ways: (1) by implementing programs which systematically integrate (rather than segregate) deviant persons into community schools, industry, recreation, etc.; (2) by employing culturally typical labels and names, for both persons and services, such that the deviant person is interpreted in image-enhancing rather than deviancy-laden terms; and (3) by service buildings which are perceived as culturally typical by the public at large (Wolfensberger, 1972).

Normalization and the New Rehabilitation Legislation

Regulations recently signed by the Secretary of the Department of Health, Education, and Welfare (HEW) to implement Section 504, concerning the civil rights of persons with handicaps of the Rehabilitation Act of 1973 have a strong, normalizing emphasis of integrating the handicapped person in work, education, and health and social services (Fields, 1977). In employment, for example, any program receiving funds from HEW is now required to make "reasonable accommodation" to handicapped employees or job applicants, including such actions as job restructuring, providing part-time employment, and making physical facilities accessible. It is a violation of the law to unnecessarily segregate or congregate persons with disabilities.

In education, the new regulations require schools to provide programs and activities in the most integrated setting appropriate. Colleges and universities must furnish handicapped students with needed auxilliary aids, such as tape recorders and seeing-eye dogs for the blind, and are forbidden to counsel handicapped students towards careers that are more restricted than those towards which non-handicapped students are guided.

In social and health services, agencies receiving funds from HEW are required to operate in such a fashion that persons with speech or sensory impairments can communicate adequately with staff.

Normalization and Socio-sexual Behavior

The same ideological ferment that is currently at work to change the shape of services to disabled persons in education, housing, work, etc., can also be discerned in the area of sexual development and behavior. Until rather recently, social attitudes have been such that handicapped persons were frequently denied not only the opportunity and privilege of marriage and procreation, but even that of hetero-sexual integration. In one U.S. institution in the Midwest, between 1894 and 1944, no fewer than 656 castrations were performed on retarded men (Perske, 1973). Dybwad (1976) comments that "in no area have we de-normalized and dehumanized the severely physically disabled person as much as in the sphere of the sexual life (p. 12)". Currently, however, it would appear that human services are becoming considerably more open in this respect, and the normalization principle provides a powerful rationale for making efforts to elicit and support normative sex behavior more thorough and systematic.

Any program receiving funds from HEW is now required to make "reasonable accommodation" to handicapped employees or job applicants, including such actions as job restructuring, providing part-time employment, and making physical facilities accessible. It is a violation of the law to unnecessarily segregate or congregate persons with disabilities.

From a normalization perspective, agency programs should actively support and encourage (without actually imposing) culturally normative socio-sexual experiences for all persons served, no matter what the nature or degree of the impairment. Supportive activities might include coeducational programs; curricular and extracurricular social opportunities, such as the integrated social clubs for young people in Sweden (Wolfensberger, 1972); sex education; exposure to appropriate peer models, including both male and female staff; skillful counseling; and premarital and marriage courses (Wolfensberger & Glenn, 1975).

Habilitative services must be conscious of the need for appropriate sexual development and identity throughout the lifespan, from infancy to old age. Young children, for example, need prolonged exposure to heterosexual socialization and sex-role models appropriate to each sex. Adolescents must be able to participate in heterosexual dating and relationships. And service agencies must provide the climate and ongoing supports needed to allow handicapped men and women to choose and lead married lives.

Evaluating Agency Success in Promoting Normative Sex Behavior

An evaluation instrument now exists by means of which a service agency can assess the degree to which it is successful in promoting normative behavior (including age and culture-appropriate sex behavior) in the persons it serves. This instrument is called PASS (Program Analysis of Service Systems; Wolfensberger & Glenn, 1973; 1975), and it is based largely on the normalization principle.

PASS as an Evaluation Tool

PASS permits a team of trained raters to assess service program quality on 50 different aspects or "ratings". Each rating is made according to detailed guidelines contained in the PASS *Field Manual.* Individual team members first rate a service independently. Later, any differences among individuals' ratings are resolved through a team conciliation session, and a team-conciliated scoresheet and detailed report are sent to the agency.

From a normalization perspective, agency programs should actively support and encourage (without actually imposing) culturally normative socio-sexual experiences for all persons served, no matter what the nature or degree of the impairment.

Scores on the 50 rating items are summed to yield a single index of overall program quality, the total PASS score. The latter has a maximum of 1,000 points, and reflects program and agency characteristics which bear upon service quality. The total PASS score is distributed over three major categories: adherence to the principles of normalization and integration, 73 percent of the total score; other ideologically-based service and administrative practices, 13 per cent; and administrative operations, 14 per cent.

PASS was designed to be applicable to a wide range of human service programs and agencies, including services in mental retardation; emotional disorders; physical handicap; aging; addictions; child development programs; special education classes; rehabilitation centers and workshops; residential services; mental health clinics, etc. This wide applicability derives from the fact that each of the individual PASS ratings measures agency performance on a human service "universal"—an issue (such as socio-sexual behavior) which *any* agency or field must meet successfully in order to have services of high quality (as defined in terms of normalization/integration and effective agency administration).

The PASS Rating, "Age-appropriate Sex Behavior"

In PASS, "Age-appropriate sex behavior" is one of the 50 ratings on which service quality is measured. An agency program is assigned one of five possible "levels" of performance on the rating, according to guidelines stipulated in the *Field Manual.* The five levels on "Sex behavior" are the following (see Wolfensberger & Glenn, 1975, *Field Manual,* pp. 30–31, for a more detailed discussion):

Level 1 (grossly deficient performance): Programs meriting a level 1 rating include any project which engages in grossly inappropriate practices. Examples include gross denial of the socio-sexual needs of clients, as exhibited by restrictions on opportunities for heterosexual socialization—even to the extent, perhaps, of sexual segregation of young children (as has been common in institutional settings). Or, a program might practice a gross sexism which is incompatible with contemporary cultural awareness of the need for a wider range of vocational, residential, and related options for both sexes.

Level 2 (less than acceptable performance): Agencies earning a level 2 rating include those which show significant but not gross shortcomings. In such programs, for example, clients might be permitted to engage in age-appropriate interaction with the opposite sex, but receive inadequate support or guidance from staff. Or, children and adolescents might be pushed prematurely towards sexuality. Or, staff might convey to clients that *only* marriage and/or childbearing are appropriate options for adults, and portray singleness or childless marriage as unacceptable alternatives.

Level 3 (minimally acceptable performance): In such agencies, clients are permitted to engage freely in age-appropriate socialization with members of the opposite sex, and would also be encouraged in such behavior through supportive services such as planned programs of heterosexual socialization; sex counseling; and sex education. Also, in such agencies attitudes towards appropriate sex roles for various ages in our culture today would be open-minded and accepting of clients' attempts to seek their own socio-sexual identity.

Level 4 (expected level of performance): In such programs, staff internalize and *extensively* implement a commitment of highly appropriate socio-sexual development of clients. Supports might include guidance and counseling; sex education; models and opportunities for appropriate behavior; etc. At the same time, certain improvements in agency commitment or practice would still be feasible.

Level 5 (ideal performance): In such agencies, age-appropriate sex behavior are so advanced as to constitute a model for others, and further improvements would be difficult to conceive of at the present time.

Some Preliminary Empirical Findings on Current Agency Performance

One recently completed PASS study (Flynn, 1977) contains some suggestive evidence that human service agencies are

not particularly aggressive or successful in fostering normative sex behavior in their clients. The study consisted of an analysis of 151 program evaluations carried out in the U. S. and Canada during 1973–75 with an earlier (second) edition of PASS (Wolfensberger & Glenn, 1973). Ninety-three per cent of the programs evaluated were in community-based agencies, and 72 per cent were in the field of mental retardation. Half were for adult clients, with 30 per cent for school-aged children and adolescents. Thirty-seven per cent were community residential programs, with 21 per cent vocational rehabilitation programs, and 11 per cent special education services. Fifty-six per cent were in the U.S., and 44 per cent in Canada. Reliability of the PASS instrument, using Cronbach's coefficient *alpha,* was .90.

On the rating of "Age-appropriate sex behavior" (similar in content to the same rating in the third edition of PASS), the 151 service programs had a mean score of 5.6 out of a possible 20 points, or only 28 per cent of the maximum possible score. Moreover, out of 41 PASS 2 ratings, "Age-appropriate sex behavior" ranked far down the list, in 27th position, in terms of relative adequacy. Service quality on the rating was not grossly deficient, but neither was it close to the ideal level (as the latter is defined in the PASS guidelines for the rating).

The findings of the Flynn (1977) study, although tentative, do suggest that human service agencies have little cause for complacency, and that vigorous efforts to support and guide clients in achieving maximally normative socio-sexual adjustment may be rather widely called for.

Suggestions for Optimizing Normative Sexual Development

The data on which the author's earlier study (Flynn, 1977) was based were further analyzed, to clarify the correlates of agency performance on the rating of "Sex behavior". The 15 PASS 2 ratings with the highest zero-order correlations (*r*) with "Age-appropriate sex behavior" are listed in Table 1, and are grouped according to the service program area to which they most immediately relate.

The strongest correlate of normative sex behavior is "Socially integrative social opportunities" ($r = .54$), a rating which directly taps the degree of success an agency has in achieving social integration, the ultimate goal of normalization. However, other program elements (physical integration; age- and culture-appropriate interpretations of clients; service model coherency; etc.) are also associated with normative sex behavior (Table 1). We conclude by translating these empirical relationships into suggested guidelines for improving the quality of sex-related agency services.

Suggestions for Agency Action

1. The various correlates of agency success in fostering normative sex behavior suggest, most generally, that agency efforts to improve services in the area of sexual development should take many other program aspects into explicit account. Agencies will probably be most successful if they use a blend

Table 1

Major Normalization-related Correlates[a] of Normative Sex Behavior[b] in 151 Human Service Programs Assessed with PASS[c], 1973–75.

Normalization-related Area of Program	PASS Rating[a]	Zero-order Correlation (*r*) with PASS rating, "Age-appropriate sex behavior"
1. Physical Integration	1.1 Service setting size or dispersal	.32[d]
2. Social Integration	2.1 Socially integrative social opportunities	.54
	2.2 Utilization of generic services	.33
	2.3 Lack of other deviant contact	.30
3. Age-Appropriate Interpretations	3.1 Age-appropriate labels & forms of address	.46
	3.2 Age-appropriate personal appearance	.44
	3.3 Age-appropriate autonomy & rights	.41
	3.4 Age-appropriate facilities, environmental design, & appointments	.35
	3.5 Age-appropriate activities, routines, & rhythms	.33
	3.6 Age-appropriate possessions	.31
4. Culture-Appropriate Interpretations	4.1 Culture-appropriate labels & forms of address	.37
	4.2 Culture-appropriate personal appearance	.34
5. Model Coherency	5.1 Specialization of the management model	.41
6. Developmental Growth Orientation	6.1 Lack of social overprotection	.37
	6.2 Intensity of relevant programming	.34

[a] 15 PASS 2 ratings (*Wolfensberger & Glenn, 1973*) correlating most strongly with "age-appropriate sex behavior", among all 41 PASS 2 ratings. See text for explanation of ratings.

[b] As measured by PASS 2 rating, "age-appropriate sex behavior" (*Wolfensberger & Glenn, 1973*).

[c] Second edition (*Wolfensberger & Glenn, 1973*).

[d] All correlations significant at .01 level (*two-tailed*).

of *direct* supportive services, such as sex counseling and premarital courses, *together with* a generalized effort to maximize normalization and integration in other areas—socially integrative activities; physical integration of facilities; emphasis on developmental growth; etc.—which are likely to have an interactive, cumulative impact on normative sex behavior. A narrow focus on sexuality *only* will probably meet with much more limited success.

2. Opportunities for socially integrative activities are strongly correlated with normative sex behavior (r = .54; Table 1). Efforts to maximize personal social integrgtion of clients in housing, work, education, recreation, worship, etc., are thus likely to be associated with enhanced normative sexual functioning. By the same token, other social integration-related program elements—utilization of generic services (r = .33) and avoidance of client contacts only or mainly with other (deviant) clients (r = .30)—are also likely to make a contribution to more normative sex behavior.

The findings of the Flynn (1977) study, although tentative, do suggest that human service agencies have little cause for complacency, and that vigorous efforts to support and guide clients in achieving maximally normative socio-sexual adjustment may be rather widely called for.

3. Physical integration of the agency building appears to be of some importance for sexual functioning. Small size and dispersal of service facilities throughout a service region (r = .32) can contribute to enhanced sex behavior, both by encouraging relationships between clients and persons outside the agency setting, and by avoiding the image obstacle that congregating (deviant) clients in large numbers almost unavoidably creates.

4. It is important for optimal sexual adjustment that agencies interpret and serve their clients in a fashion appropriate for their age, because treating adults as children (or vice versa) is virtually guaranteed to demoralize and denormalize. The correlates reported in Table 1 suggest that sex behavior will be optimized if agency staff are sensitized to addressing clients age-appropriately (r = .46); to clients' personal appearance (r = .44); to clients' autonomy and rights (r = .41); to the fit between clients' age and the design, furnishings, and other appointments of the agency setting (r = .35); to the daily, weekly, and monthly routines and schedules to which clients are exposed (r = .33); and to the kinds of personal possessions (e.g., clothes or money, for adults; toys for young children) which clients are encouraged to acquire (r = .31). (r = .31). Sensitivity to normalization in these respects will almost certainly increase sensitivity to age-appropriate sexual interaction, experiences, and functioning.

5. Judgments about normativeness and deviancy are culture as well as age-linked, and often transcend the question of client age. For example, good grooming, or attractive appearance, or normative mannerisms are desirable in a person, no matter what his or her age. Agencies that stress clients' culture-typical personal appearance (r = .34) or that bend over backwards to address and describe clients in culturally valued ways (e.g., "employees" instead of "clients", for retarded *workers*; "person with epilepsy" instead of "[an] epileptic"; etc.; r = .37) are likely to create services which enhance normative sex behavior as well.

6. A particularly potent means of improving socio-sexual functioning appears to be that of sharpening, towards greater adaptedness to individual client needs, the focus and overall coherency of the service model used in a particular program. The agency that makes its model more "specialized"—highly appropriate to individual clients needs—appears likely, by that very fact, to find improvement in the area of normative sex behavior (r = .41).

7. Our culture puts a high value on continual growth and development. Agencies that promote such growth in clients by refusing to over-protect or deny them culturally-normative risks (r = .37), and by achieving a high degree of intensity and relevancy in their clinical programming (r = .34), are also likely to be those in which socio-sexual growth is optimized.

8. Finally, training agency staff in the principles of normalization and human sexuality (see, for example, Sha'ked & Flynn's (1977) normalization-based curriculum) is a direct and feasible way of implementing the foregoing action suggestions.

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Tools for aiding physically disabled individuals increase independence in dressing

Jacquelyn Orlando Yep

Where to Locate the Information

Family members and professionals working with persons with physical disabilities have faced the challenge over the years of meeting the special clothing needs of physically disabled individuals. Attempts have been made to resolve the individual clothing problems associated with different types of physical disabilities.

As successes were attained by one ingenious parent or through a creative research project, additional solutions for clothing-related problems were added to the available knowledge. This approach, however, has resulted in several problems. First, the availability of such information is somewhat limited. Individuals who could make immediate use of the information often do not know where to find it or that it may even exist (Yep, 1976). Second, the information that is available in articles, pamphlets, unpublished master's theses and books is repetitive and offers the lay person or professional looking for suggestions for an individual no choice but to survey the existing suggestions and sort out those which may be applicable. Many studies undertaken at the university master's level deal with one specific disability. Such is the case of a study concerned with clothing problems for young girls with cerebral palsy which concludes with some excellent ideas on how to adapt clothing to meet specific clothing needs (McGuire, 1970). The suggestions given could be related to other girls with cerebral palsy; however, some of the suggestions could be just as helpful to a girl with spina bifida. Examination of "why" leads to a missing intermediate stage of identifying the disabling conditions present in the disease or injury.

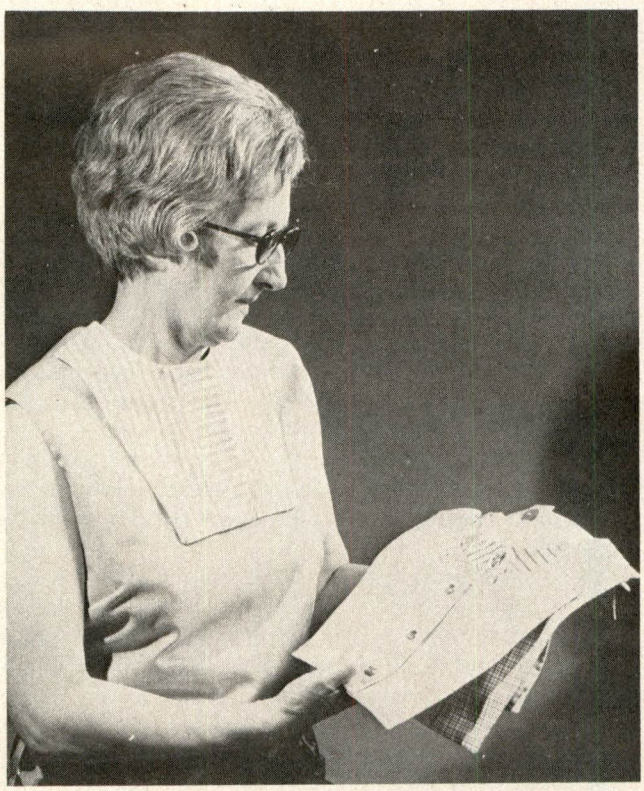
Once the disabling conditions are identified, commonalities among diseases can be seen. The individual's clothing problems can then be analyzed in terms of the disabling conditions. For the nonmedically educated person this provides a more realistic means of assessing an individual's physical abilities than a superficial knowledge of diseases. Evaluating clothing problems and solutions by disabling conditions rather than by disease or injury can lead to increased use of the clothing knowledge that is in existence today.

In an effort to assist extension home economists in consulting with physically disabled individuals concerning clothing-related problems, a two-stage framework was developed. Stage one relates diseases or injuries to possible disabling conditions. Stage two relates disabling conditions to clothing suggestions. This framework provides a tool for individuals working with physically disabled persons in analyzing possible clothing problems and offering possible suggestions which may resolve these problems. Since each individual has a unique set of abilities and limitations the framework is intended to be used as a guide for individual consultation, rather than as a prescription.

Stage One: Identifying Disabling Conditions

The extension home economist was being prepared to work with physically disabled individuals and groups upon referral from health-related professionals in her community. Coming from a non-medical background her understanding of diseases and injuries was limited to personal knowledge and experience. In her role as a clothing consultant she would need to communicate with the professionals she would work with, including physicians, nurses, physical therapists, occupational therapists, and rehabilitation counselors. Basic knowledge about the type of disabling conditions to expect for certain diseases or injuries was needed.

To develop the framework, fourteen diseases or injuries plus the condition of aging were identified. These conditions were selected because they could be directly related to clothing problems. Each of these diseases or injuries was briefly defined and possible disabling conditions were identified in chart form* (Yep, 1976; Merck and Co., 1972; Taber, 1972). The definitions and disabling conditions were developed from medical references and reviewed by a group of medical professionals. By referring to this chart, the home economist had access to practical information concerning the disease or injury. She was alerted to what possible disabling conditions may exist and she was better prepared to deal with the second stage of identifying possible clothing-related suggestions.



In her role as a clothing consultant she would need to communicate with the professionals she would work with, including physicians, nurses, physical therapists, occupational therapists, and rehabilitation counselors. Basic knowledge about the type of disabling conditions to expect for certain diseases or injuries was needed.

Stage Two: Identifying Clothing Suggestions

Once alerted to the possible disabling conditions, the home economist would need assistance in making clothing suggestions that relate to these conditions. The disabling conditions had to be organized into a systematic format for logical sequence, easy reference and continued expansion. Existing classifications and taxonomies for physical movement were examined by the author.

Research findings and information on clothing suggestions for the disabled were organized into the psychomotor domain taxonomy (Harrow, 1972), which deals with motor ability from the basic fundamental movements to skilled fine motor control. Corresponding clothing suggestions were made for each disabling condition by interpreting the psychomotor classifications as disabling conditions. A systematic classification system was thus developed to provide a base from which clothing suggestions in existence in current research and publications could be incorporated.

Basic fundamental movements make up the first category of disabling conditions. These movements are based upon reflex movements and form the basis for more complex movements. These include resistance to movement or body stiffness, large motor movement resulting in limited range of motion and simple small motor movements. Conditions of special movement also fall with this category. Wheelchair confinement, wearing of braces and the use of crutches all are included under conditions of special movement.

The second category in this analysis of motor ability is perceptual abilities. These abilities enable the individual to interpet stimuli and thus make the necessary adjustments to the task or environment. Body awareness is one of these abilities which has implications for sensory loss and reaction time. Sense of balance and visual discrimination are also areas within this category having implications for dressing.

Physical abilities comprise the third category which provide the individual with the endurance and strength needed in the dressing process. Physical control over incontinence and drooling are also a part of this area of ability.

The fourth and final category is skilled movements. This area includes the complex motor manipulation, being able to manipulate fingers to perform complex dressing techniques such as tying a shoelace.

* Charts are available from the senior author.

The Classification System In Use

In the operation of the clothing consultation service through the Iowa Cooperative Extension Service, the home economist would receive calls from health-related professionals requesting her help on the clothing aspect of rehabilitation. The home economist would be told type of disease or injury of the individual for whom the consultation inquiry was being made. Identification of a particular disease or injury alone did not provide enough information to the home economist to base clothing-related suggestions. She, however, could refer to the chart on diseases and disabling conditions and have a better understanding and indication of what possible disabling conditions would be present. She could prepare herself for the consultation by referring to the clothing suggestions related to the possible disabling conditions. She would then be able to select the evaluation tools and clothing samples that she would be most likely to need for the consultation. It would only be after personal observation and consultation with the individual that the presence and severity of the disabling conditions would be known. Because of the systematic organization of the process prior to the consultation, she is prepared to give specific assistance. She is alert to possible conditions to look for and has available an organized collection of clothing suggestions for the conditions which she may encounter.

Because of the systematic organization of the process prior to the consultation, she is prepared to give specific assistance. She is alert to possible conditions to look for and has available an organized collection of clothing suggestions for the conditions which she may encounter.

Skill evaluation tools can be constructed around the disabling conditions so than an individual could try out different clothing suggestions during a consultation session. Such was the case with a bodice front developed with removable yokes. This device allows the person with limited small motor movement to discover what closures are easier to use.

Expanded Use of the Classification System

This two-stage classification system proved helpful in preparing extension home economist to serve as clothing consultants. The home economists found it to be a practical tool for them as they provided the consultation service. It has demonstrated its usefulness in drawing together information on clothing for the disabled into a practical format that can help provide assistance to disabled persons with clothing problems.

In addition to its utilitarian purpose, it provides a higher level of organization for information of this nature. Once the currently known clothing suggestions were classified according to disabling conditions, areas where little information or research was available become evident. As an indication of suggestions for future research, the classification system could provide direction to minimize repetitive research and emphasize the areas which would bring new ideas into the available data. The classification system is a beginning framework upon which new and additional ideas can be tested and incorporated. It provides, therefore, not an end but a means for continued expansion of the knowledge of clothing for the disabled while enabling the information currently available to te be used to assist disabled individuals overcome clothing problems in the rehabilitation process.

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EMPLOYMENT OF THE CERTIFIED REHABILITATION COUNSELOR

Lawrence B. Feinberg

Throughout the past few years, "certification" has been a salient issue for rehabilitation counselors and those who employ them. The program for rehabilitation counselor certification was implemented during the 12-month period from July 1, 1974 to July 1, 1975, by the Commission on Rehabilitation Counselor Certification (CRCC). In recognition of the potential impact which certification would have on all aspects of the rehabilitation counseling field, CRCC included representation not only from the two major professional organizations representing rehabilitation counselors (American Rehabilitation Counseling Association and National Rehabilitation Counseling Association) but also from organizations representing employers of rehabilitation counselors in both the public and private sectors (Council of State Administrators of Vocational Rehabilitation and Association of Rehabilitation Facilities), the organization representing rehabilitation counselor educators (National Council on Rehabilitation Education), the national accreditation group in the field of rehabilitation education (Council on Rehabilitation Education), and representation from consumer groups (American Coalition of Citizens with Disabilities). The response of rehabilitation counselors to the certification program has exceeded all expectations; by January 1, 1977 over 8,500 rehabilitation counselors had been successfully certified (CRCC, 1977).

The certification process currently provides professional recognition of minimum standards of counselor competency based on education, experience, peer and supervisor evaluation and a standardized national examination.To date, it has imposed no controls or restraints on the delivery of services to rehabilitation clients; public and private rehabilitation agencies are not required to hire certified rehabilitation counselors. At the November 22, 1976 meeting of the Rehabilitation Services Administration Advisory Council on Rehabilitation Counseling, the Advisory Council recommended that the Rehabilitation Services Administration support legislation and other efforts which would require state-federal and private rehabilitation agencies utilizing rehabilitation counselors to employ only the Certified Rehabilitation Counselor (CRC). The purpose of this paper is to provide a position statement in support of the Advisory Council's recommendation which would reflect the issues, concerns, benefits and potential pitfalls most relevant to rehabilitation counselor education.

Submitted as a position paper to the National Council on Rehabilitation Education (NCRE).

The author would like to acknowledge the substantive comments and suggestions of the members of the NCRE Professional Standards Committee during the preparation of this paper.

The major factors which form the basis of professional support of legislation requiring certification for employment as a rehabilitation counselor in public and private agencies seem to fall into two general categories. The first concerns the proposition that such a requirement would enhance professionalization through an increase in professional independence and prestige and a decrease in identity problems. The second deals with the proposition that requiring certification for employment would upgrade services to clients by assuring that the practicing rehabilitation counselor has met minimum standards of competency. These two issues seem to be the major reasons why most rehabilitation counselors desire certification (Hansen, 1977) and why the certification movement has been generally supported by the various professional associations in the field.

Enhancing Professionalization

Currently there is no nationwide uniform standard of education or experience for employment as a rehabilitation counselor in a public or private facility. While a few state agencies and some facilities require a master's degree as the minimum educational requirement for employment as a rehabilitation counselor, very often the degree does not even have to be in a field related to rehabilitation counseling. Other state and private agencies hire rehabilitation counselors at the baccalaureate level. Entry level experience requirements vary widely and rarely specify that it include systematic supervision by a qualified rehabilitation counselor.

By requiring certification as a condition for employment as a rehabilitation counselor in public and private agencies, a basic and uniform level of training and experience for professional practice would be established. As a result, the professional identity of the rehabilitation counselor would be greatly enhanced not only within the field of rehabilitation but also among the other professional helping groups. Virtually all other helping professions which are viewed as fully legitimate providers of health and medical services, have adopted self-regulatory certification or licensing procedures. In the related fields of medicine, psychiatry, psychology, social work, nursing, and physical therapy, a requirement of certification or licensure for employment under the corresponding professional title is commonplace.

Public and private rehabilitation agencies have already established numerous precedents with regard to the employment of certified or licensed professionals. For example, most state vocational rehabilitation agencies now require that professionals from whom they purchase services be certified or licensed (i.e., physicians, psychologists) although paradoxically there are currently no such requirements of the professional rehabilitation counselors whom they employ. Moreover, the standards of the Council on Accreditation of Rehabilitation Facilities (CARF), which must be met by any

private rehabilitation facility seeking accreditation, already state:

> "When standards of qualification have been established by recognized professional groups, the facility shall adopt not less than these as minimum requirements for its respective professional staff" (CARF, 1976).

The need to enhance and legitimize the professional status of the practicing rehabilitation counselor has been underscored by the recent spate of licensing proposals emanating from various state legislative bodies. Many of these bills reflect the view that rehabilitation counseling is not a recognized professional identity and that rehabilitation counselors should therefore be placed under the supervision of a "recognized professional"; i.e., a certified or licensed social worker or psychologist (Hansen, 1977). The absence of uniform criteria for employment of rehabilitation counselors has also contributed to the confusion over the nature of the role of the rehabilitation counselor and the standards of competence required to perform specific rehabilitation counseling activities. Consequently, rehabilitation counselors have, as yet, not been included in the standards for rehabilitation personnel of the Joint Commission on Hospital Accreditation and have encountered difficulties in negotiating with insurance carriers for reimbursement of fees charged for services rendered by a "qualified" professional (Gianforte, 1977).

It is obvious that any enhancement of the professional status of rehabilitation counselors would be in the interest of rehabilitation counselor educators. There is no question that the high standards of professionalism currently held by graduate rehabilitation counseling programs are substantially diminished by the lack of uniform entry criteria for employment of the practicing rehabilitation counselor. Graduates of rehabilitation counselor education programs must compete for entry level jobs with persons with substantially less training and/or experience who are willing to work at substantially lower levels of compensation. Moreover, graduate trained rehabilitation counselors suffer considerable loss of prestige and morale when they are not distinguished from and are employed at equal levels with persons with substantially less training or experience. The absence of uniform employment standards for rehabilitation counselors in public and private rehabilitation facilities has even lead to the anomalous situation of having graduate students serve internships under employed rehabilitation counselors who have less training and experience than the graduate student.

Upgrading Services to Consumers Through Assurance of Basic Competency

The recent federal mandate to deliver rehabilitation services to the severely disabled has served to emphasize the need to insure that the body of rehabilitation counselors available to deliver those services meet the high levels of competence which are consistent with this difficult and complex task. A major argument in support of requiring certification as a condition of employment of rehabilitation counselors is that such a regulatory policy would protect the consumer by setting and controlling minimum competence levels and thereby upgrade the quality of rehabilitation services. In the absence of such procedures and in the light of the wide variability of employment criteria currently being used, the title "Rehabilitation Counselor" offers the public no assurance of basic levels of professional competence on the part of those who use that title. By establishing minimum academic and experience requirements as well as uniform competency evaluations through standardized nationwide examinations and peer and supervisor evaluations, certification directly benefits the consumer through an upgrading of the minimum levels for professional service delivery.

Requiring certification as a condition of employment has been criticized by some as being "anti-consumer" since, it is argued, it would presumably deprive consumers of freedom of choice in selecting counselors. While such a procedure probably would limit the consumers' freedom to choose a counselor with less than minimal qualifications, it would guarantee consumers an important voice in setting hiring qualifications. Unlike other certification bodies, the Commission on Rehabilitation Counselor Certification has, from the outset, recognized the need to involve consumers directly in the certification process itself. Consumer groups are represented on the Board of Directors of CRCC as well as on each of its committees and play an integral role in determining certification policies.

Any effort to upgrade the quality of client services would certainly be congruent with the basic objectives of rehabilitation counselor education. Rehabilitation counselor educators have played a major role in providing highly qualified rehabilitation counseling personnel through long term, short term, inservice and continuing education programs. The impact of graduate rehabilitation counselor education on the level of client service delivery has, however, been greatly limited by the reluctance of many employers to recognize the significance of the Master's degree in Rehabilitation Counseling in formulating job entry requirements. Virtually every other established profession requires a standard professional education as a condition of entry into the profession.

While establishing the "C.R.C." as a job entry requirement would not completely alter this situation, it would at least be a step in the right direction since graduate education in rehabilitation counseling is recognized in the eligibility criteria for certification. Moreover, approximately 50% of the CRC's currently hold Master's degrees (Livingston, 1977) and that proportion should increase dramatically with the completion of the "grandfathering" phase and the growing number of persons seeking certification under the pass-fail provisions now in effect. Finally, requiring certification as a condition of employment as opposed to exclusively requiring the Master's degree in Rehabilitation Counseling, has the advantage of not foreclosing job opportunities to qualified persons who may have attained an equivalent level of competency through a combination of experience and training in related disciplines. Rehabilitation counselors have often been the brunt of discriminating hiring policies involving specific degree requirements and it would hardly be fitting for Rehabilitation Counseling Educators to advocate similarly restrictive policies.

Benefits and Implications for Rehabilitation Counselor Education

Legislation requiring state and private agencies to hire Certified Rehabilitation Counselors would almost certainly have the effect of strengthening the viability of rehabilitation counselor education programs. The most tangible benefit provided should be the added stimulus to student recruitment from among those persons seeking entry into the rehabilitation counseling field. Such persons would readily see the advantage that a graduate education in rehabilitation counseling offers in meeting the eligibility criteria for certification.

In accordance with a recent change in the CRCC Standards and Criteria for Certification, persons applying for certification after January 1, 1978, who hold a Master's degree in Rehabilitation Counseling from an accredited rehabilitation counselor education program will not need to meet a minimum experience requirement (since their training would include a one year supervised internship) and will be eligible for the certification examination immediately after graduation (CRCC, 1977).

The most tangible benefit provided should be the added stimulus to student recruitment from among those persons seeking entry into the rehabilitation counseling field.

RCE programs should also benefit from an increase in interest in graduate training from among those currently non-certified practitioners who lack specific training in rehabilitation counseling and wish to enhance their skills and their performance on the certification examination. Emerging research evidence indicates that persons with graduate majors in Rehabilitation Counseling perform consistently better than those with other types of training on areas of the certification examination directly related to rehabilitation (Livingston, 1977).

Finally, certification maintenance procedures currently being developed by CRCC now include continuing education as a major vehicle for achieving recertification. Rehabilitation counselor education programs are clearly in an excellent position to provide such educational experiences and should benefit directly from the ongoing demand for both short and long term training which will be created by the establishment of such minimum standards of continuing education. It is certainly likely that once certification was established as a requirement for initial employment as a rehabilitation counselor, certification maintenance would soon be mandated for continuing employment in the field.

Potential Problems and Objections

There seems little doubt that requiring certification for employment as a rehabilitation counselor will bring pressure to bear on rehabilitation counselor educators to present a more united position on program design and objectives which is consistent with the definition of professional role and practice implicit in the certification standards. Curriculum content and emphasis may need to be revised so as to reflect an awareness of current certification procedures and of the nature of the certification examination. As McAlees (1975) has pointed out, the certification examination is a "practice-based examination" and "items included in the examination put a higher premium on the application of knowledge in managing clients rather than in isolated bits of factual information." The potential for using certification examination data as a criterion for validating individual RCE program effectiveness will also be a major issue. Educators will undoubtedly be confronted with the question of whether their programs should encourage innovation or emphasize normative modes of professional practice revealed in analyses of the results of the certification examination.

The current proposal is open to a number of potential objections from various segments of the field. For reasons too numerous and too complex to elaborate here, it should be recognized that not all rehabilitation counselor educators equally support the current certification program. Differences in attitudes, philosophy and orientation of rehabilitation counselor educators toward the basic concept of certification cannot be separated from reactions to this specific proposal. It is likely, however, that resistance to legislation requiring state and private rehabilitation agencies to hire only certified rehabilitation counselors could occur in the form of the following criticisms:

1. At this point, there is no hard data to demonstrate that certified rehabilitation counselors are more competent than non-certified counselors.
2. Many of the smaller private facilities and workshops will not be able to afford to hire certified rehabilitation counselors. The education/experience factors required for certification would price these people out of the range for many of these facilities.
3. Problems would arise in developing procedures to be used in handling the cases of staff who are already employed as rehabilitation counselors, but are not eligible for certification due to education and/or experience deficiencies.
4. Since certification currently recognizes experience as a legitimate route to gaining professional competence, how would an individual get that experience if he/she must be certified to be employed?
5. How do we answer the charge that educators are trying to get this legislation passed solely to enhance the training programs by making the job requirements better suited to the graduates?

There is no doubt that we will need to develop sound answers and solutions to the very real and serious problems raised by these questions and criticisms. The potential upgrading of services to rehabilitation consumers, the opportunities to further enhance the professionalization of our field, and the direct benefits to rehabilitation counselor education, which have been identified in this paper, would all appear to be compelling reasons to support this proposal. The ultimate question, however, is how employers will respond to the proposed legislation and the inevitable problems associated with it.

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The Role of Job Coaching In Vocational Rehabilitation

To successfully coordinate and direct diversified needs, attitudes and skills into the competitive labor market requires a special kind of specialist.

Raymond C. Doane
Michael E. Valente

Introduction

A rather sizeable proportion of the nation's adult men and women experience a "handicap" resulting from a disabled body function, mental, physical, or both. Many of those men and women persist, however, in their desire, drive, and potential to achieve personal independence and success on a specific payroll job. Further, many of them have ample abilities to function acceptably to excellently in the competitive labor market.

Handicapped men and women possessing saleable skills and attitudes have a rightful place in the remunerative world of work. As citizens, they also have a responsibility to serve as a contributor to the existing economy. Many individuals who experience disabled body functions are striving with a great deal of determination to compensate for the disability and become employable. Being employable and receiving reasonable wages influences one's life style and the extent to which one may live independently. It is well-known that independent living is one of the most realistic aims of the total vocational rehabilitation process.

The human body is indeed a "complex machine." Most "complex machines" have innate capabilities to perform a wide variety of body functions such as: seeing; hearing; speaking and communicating; thinking and reasoning; eating, drinking, and voiding; neuro-musculo-skeletal flexing, controlling, and coordinating; cardiovascular systeming; respirating; and glandular systeming. Individuals who have all their body functions in "working order" are knowingly fortunate. On the other hand, individuals with body functions not in "working order" generally need a correctional or compensational arrangement involving a combination of medical, educational, vocational, and mechanical services. The point is: those individuals need special help, whatever the arrangement might be, to develop and maintain "job readiness" for employment in the competitive labor market.

An emerging concern in vocational rehabilitation today is the matter of helping those clients who possess sufficient capabilities to perform acceptably to excellently in competitive employment. Those clients are among the "very able disabled." The nature of the follow-up and follow-along services for them in competitive employment situations is often minimal. Given the right kind of opportunities for employment in the labor market, their success is possible and very likely.

There is another group of rehabilitation clients whose capabilities are somewhat less than the "very able disabled." With the right kind of job readiness activities and experiences, they too, may achieve measures of occupational success in the world of work. They may initiate their work experiences in a sheltered workshop and continue to develop their job readiness in preparation for competitive employment. Client success in a sheltered workshop employment center is important and admirable. However, when possible, those clients should be readied for employment in the competitive labor market. Occupational entry and success should be an ultimate goal. Assistance by job coaches to help them reach that goal is essential.

A client worker who is designated as "job ready" by counselors and occupational specialists may profit from the services of a skilled vocational rehabilitation professional known as a "job coach." The process of job coaching is now

becoming an integral part of vocational rehabilitation. The primary thrust of job coaching is client functioning, performance, and success in an occupation.

What is Job Coaching?

Job coaching is an important employment-centered activity within the vocational rehabilitation process. The focus of job coaching is upon counseling, encouraging, and assisting a client or group of client workers to adapt to (a) conditions of remunerative employment, (b) a specific work station, and (c) a specific place of employment, all within competitive employment settings. The ultimate or desired outcome of job coaching is to have each client worker achieve personal and occupational independence on a specific payroll job and attain some measures of occupational success.

Handicapped men and women possessing saleable skills and attitudes have a rightful place in the remunerative world of work. As citizens, they also have a responsibility to serve as a contributor to the existing economy.

The job coach is an important member of the total vocational rehabilitation team whose primary talent is found in the services rendered at a place of employment. His services are intended to benefit (a) clients, (b) co-workers of clients, (c) supervisory or mid-management personnel working directly with clients, and (d) the top level managerial persons. The responsibility of the job coach is twofold: client readiness and adjustment to competitive employment, and client worker performance and occupational success. Inherent activities of job coaching usually encompass the resolution of client's problems classified as: (a) personal, (b) general or continuing education, and (c) vocational or job preparation.

What Does a Job Coach Do?

The primary responsibility of a job coach has a definite focus upon "people relationships." Those relationships are with the client worker, vocational rehabilitation counselor, coordinator of job readiness education, coordinator of job placement, employer, and work supervisor. People relationships must be in the best interest of both the client worker and the employer.

A suggested job description for functioning job coaches follows:

1. Establish working relationships with competitive employment management or mid-management personnel which foster employment successes for client workers.
2. Assist client workers in the orientation to the firm's policies, procedures, products, services, standards, fringe benefits, and opportunities.
3. Support and abide by the firm's personnel policies and practices.
4. Establish working relationships with client workers leading to self-motivation and employment success for them.
5. Work with adult and vocational education personnel to develop and maintain job readiness of client workers.
6. Be alert for and rectify situations and circumstances which tend to destroy a client worker's happiness, morale, and productivity rate.
7. Be readily available to carry out personal crisis counseling and concentrate on resolving a variety of personal, educational, or vocational problems which alters the functioning level of the client.
8. Assist supervisory personnel in establishing and achieving worker performance standards.
9. Cooperate with supervisory personnel in preparing and interpreting client worker performance evaluations.
10. Analyze and rectify, as necessary, client worker's motions at their work station for the purpose of conserving time and energy, and maintaining production or work standards.
11. Develop strategies and procedures for promoting attitudinal changes of client workers and their co-workers.
12. Assist co-workers to understand and to be tolerant of inherent psycho-socio-physio difficulties of client workers.
13. Cooperate with the client worker in the adjustment process of making the transition from employment in a sheltered workshop setting to a competitive labor market setting.
14. Work with vocational rehabilitation job placement personnel in aligning job opportunities with specific clients.
15. Be alert for and identify those work stations which could be fulfilled by a "job ready" client worker.

The primary responsibility of a job coach has a focus upon maintaining "people relationships." The job coach, be it man or woman, functions as a counselor for employees. The concentrated efforts are toward employment success of a specific individual or group of individuals. A common task for a job coach is to resolve personal, educational, and vocational problems.

What Skills Should a Job Coach Possess?

The job coach has the primary responsibility of functioning in "people relationships" dealing with matters pertaining to employment of clients experiencing disabilities. The professional preparation requirements of a job coach are indeed unique because of the nature of his obligations to the client and the employer. An orientation and experiential background in each of the following are recommended to prepare a man, or woman, to function as a job coach. (1) Personal, educational, and vocational counseling. (2) Industrial/business management, equipment, and materials processes. (3) Adult and adult basic education. (4) Technical and vocational education. (5) Psycho-socio forces for self-motivation. (6) Interview and job placement procedures. (7) Employee orientation to policies, procedures, and expectations.

How Does a Job Foreman Differ From a Job Coach?

The primary responsibility of the usual job foreman has a focus upon maintaining production controls and standards. The job foreman is generally "thing oriented" or "task oriented." The foreman is usually concerned about numbers of things completed and readied for distribution. He is in charge of those tasks performed and the productivity of a group or team of workers within a specific time frame.

By contrast, the primary responsibility of a job coach has a focus upon maintaining "people relationships." The job coach, be it man or woman, functions as a counselor for employees. The concentrated efforts are toward employment success of a specific individual or group of individuals. A common task for a job coach is to resolve personal, educational, and vocational problems. Also, the job coach works closely with the job foreman to be certain that each worker is maintaining production standards. At times, the job coach must resolve problems before and/or after the usual working day.

Rationale for Job Coaching

From a client's point of view:

Assuming the client worker has been properly informed and truly understands the role of the job coach, the client knows about the individual from whom assistance is always available. The client knows that the job coach's real function is to "coach" and assist. The client appreciates the job coach who helps to avoid embarrassment, frustration, disappointment, and excessive fatigue. Also, the client welcomes timely words of encouragement, reinforcement, and support which leads to confidence building. For most problems being experienced by the client, both on-the-job and off-the-job, the job coach is the designated person who is prepared and available to assist in resolving the situations.

From an employer's point of view:

An employer appreciates knowing that a new employee, designated as "job ready," has a trained person who is prepared and available to help that new employee sustain job readiness and be successful. The employer may rely upon assistance from the job coach to help the foreman resolve the personal problems which tend to influence one's productivity rate. It is also very apparent that all employees, with or without body disfunctions, need some kind of assistance. Establishing a division of labor for the foreman to resolve *production problems* and the job coach to resolve *personal problems* is economically sound in managerial terms of conserving time and energy.

Essentially, the job coach contributes to the continual rehabilitation process of "fitting the job to the man" and "fitting the man to the job."

From a rehabilitation counselor's point of view:

A rehabilitation counselor sees job coaching activities as ways for clients to achieve measures of success in independent living and occupational performance. Assuming the client is judged to be "job ready," the job coach may be very helpful to the counselor in the process of job placement. The job coach may also function on a daily basis to maintain job readiness and continued employment. Increased assurance of occupational success for the client is likely. The expedient nature of the follow-up and follow-along services of a job coach immediately after job placement is extremely important for the total vocational rehabilitation process. There is probably no better way for rehabilitation personnel to carry out follow-up and follow-along services than through job coaching.

Summary

Many severely disabled individuals have ample drive and capabilities to attain acceptable to excellent occupational performance levels in the competitive labor market. Given the right kind of opportunities for job preparation, placement, and continued employment, their success is likely.

Some clients may initiate their work experience in a sheltered workshop and continue to develop their job readiness preparation for employment in the competitive labor market. For many clients, occupational entry and success in competitive employment should be an ultimate goal. Assistance from job coaches toward that goal is essential.

The process of "job coaching" is a new integral part of vocational rehabilitation wherein the primary thrust is client performance and success in the competitive labor market. The prevailing task of the job coach is client readiness and adjustment to employment, work performance, and job success. The job coach is known as a problem solver for client workers who are adjusting to competitive employment. The typical description of a job coach encompasses a variety of tasks which are centered upon "people relationships." Essentially, the job coach contributes to the continual rehabilitation process of "fitting the job to the man" and "fitting the man to the job."

Myocardial infarct (MI) patients often have difficulty returning to full employment. Some patients are significantly disabled by complications of a heart attack such as congestive heart failure, arrhythmia, low cardiac out-put, and persistent angina. Other patients become psychologically depressed and although they may return to work, extreme cautiousness characterizes their performance. Presently patients usually recuperate at a physician or self-regulated pace with subjective decisions being made for return to work. Objective measurements during recuperation would help in patient management.

IMPROVED WORK CLASSIFICATION IN POST-MYOCARDIAL INFARCTION REHABILITATION

David J. Henderson
Donald Orth
Richard Robson
Joseph M. Stein

Reports of many groups have shown that selected patients with coronary disease can safely participate in a supervised training program (Rechnitzer, Pichard, Paivio et al, 1972; Frick and Katilia, 1968; Naughton, Shauhour, Armstrong, et al, 1966). Hellerstein has reported his experience with such patients showing that after training, they were able to perform muscular work much more efficiently than before training with fewer heart beats, lower blood pressure, and greater aerobic capacity (Hellerstein, 1973). Fletcher and Cantwell have reported that in organized programs, not only has myocardial oxygen consumption (MVO_2) improved, but there are associated beneficial changes in triglyceride levels and in smoking habits (Fletcher and Cantwell, 1975). Although working tolerance may be improved, the upper adjustment of work classification as described by the Dictionary of Occupational Titles has not been clearly determined. Since oxygen requirements for most occupations have been rated (Shepherd, 1972), consideration of work duration, periods available for rest, and extrapolation of training improvement can be used to determine the patient's job classification. We defined the population of patients with documented MI's and determined if these patients could improve their work classification. Physiological capabilities documented return to full employment rather than subjective criteria which at best have produced physician or patient skepticism and anxiety.

Coronary artery disease effects multi-billion dollar losses annually throughout industry. Not only are men removed from employment for months during some of their most productive years, some never return to the same occupation or to useful employment. Return to full employment would seem to be the keynote of a rehabilitation program. Because of the economic impact in the State of New Jersey, active involvement by the State in organized cardiac rehabilitation was deemed necessary.

The New Jersey Commission of Vocational Rehabilitation inaugurated a pilot study to determine the feasibility of rehabilitating post-coronary patients. Dr. Stein, Medical Consultant for the Rehabilitation Commission, directed this program with the approval of the Medical Director of the Commission, Dr. Jarvis M. Smith. The financial and administrative aspects of the program were organized by Arthur J. Sinclair and continued approval of the study was made by the present Medical Director, Dr. Daniel O'Reagan. A program was established at Anthropometrics Heart Clinic to carry out the

Coronary artery disease effects multi-billion dollar losses annually throughout industry. Not only are men removed from employment for months during some of their most productive years, some never return to the same occupation or to useful employment. Return to full employment would seem to be the keynote of a rehabilitation program.

training portion of rehabilitation for those patients who needed improved work classifications to regain full employment. We would like to report the results of this pilot program.

Procedure

The patients of this study were twenty-eight (28) unemployed men who had experienced myocardial infarction as defined by EKG and enzyme changes at least three months prior to program entry. All men were volunteers, screened for willingness to cooperate in the program, and determination of financial need. Patients were referred from physicians in private practice who were aware of the patient's reluctance in returning to work or an employer's hesitancy to permit return to full employment. All patients exhibited cardiovascular stability. Patient age and weight are described in Table I. Patients ranged in age between 29 and 58 years ($\bar{X} = 46$). The patients as a group were mildly obese ranging from 58.2 to 96.6 kilograms ($\bar{X} = 78.2$). A weight loss following conditioning was noted ($p < .01$). None of the patients prior to this study were participating in any type of rehabilitation.

Following acceptance and approval by the Rehabilitation Commission, a three appointment evaluation was arranged. The first appointment included collection of historical and laboratory data and orientation to the treadmill used for testing. A special emphasis was placed on the cardiovascular history, occupational requirements, and exercise habits of the patient. Laboratory data included SMA-12, triglycerides, CBC, and urinalysis to determine abnormalities which might warrant further medical management. There were no contraindications to exercise testing from EKG, blood pressure, or laboratory data in the accepted group.

The second appointment included patient weigh-in, complete cardiovascular examination by a cardiologist, and the treadmill exercise test. During treadmill testing, measurement of oxygen consumption, 12-lead EKG's and blood pressure responses were determined at each phase. Recovery patterns of the electrocardiogram and blood pressure were measured at one minute intervals post-test until five minutes or patient return to pre-test values. Oxygen consumption was measured with an on-line system using the Beckman LB-2, Beckman OM-11, Parkinson Cowan gasometer, and Bueckner mixing chamber. Blood pressure response was measured at 1.5 minutes into each phase. The electrocardiograms and oxygen consumption were measured simultaneously during the last 30 seconds of each three minute phase. The treadmill speed of 2.0 mph was used for initial testing with grade increments of 5% each three minute interval. Testing was terminated if abnormalities were observed in electrocardiogram, oxygen consumption, patient symptomatology, or blood pressure responses. In all cases during initial testing end points were elicited within nine minutes.

At a third appointment the patient was informed of his test results and his recommended exercise prescription (XRx). The XRx for each one of the patients was computed by a formula (Personal Communication, 1976) described in Table II. The target heart rate was individualized by using a peak testing heart rate (XHR) which did not elicit any abnormal response in EKG, blood pressure, expired gas analyses, or patient symptomatology. The resting heart rate (RHR) was subtracted from XHR and the results multiplied by the index from measurement of oxygen consumption. The resultant product was added to RHR. All patients included for regular conditioning were capable of a target heart rate of 120 b/m or greater. Prior to the rehabilitation phase, the workloads used during testing were repeated to establish test-re-test reliability ($r = .98$). Patients participated in a three month program with bicycle ergometery (Oglaend Model 980) and treadmill (Trotter C-22) modalities three times weekly for 40 minutes durations. Each session was composed of a five minute warm-up with a heart rate not in excess of 100 b/m using a bicycle ergometer, treadmill, or calisthenics. The

Table I

Physical Characteristics of Subjects

	Range	$\bar{X}$	s	t
Age (years)	29–58	46.0	8.1	
Weight (kilograms)	Pre- 58.2–96.6	78.2	10.6	
	Post- 58.6–98.2	76.9	10.4	2.169*

** Significant at .05 level*

Table II

Formula for Exercise Prescription

$$[XHR - RHR][.60 + (\text{Peak METS} \div 100)] + RHR = XRx$$

XHR = Peak testing heart rate with no abnormalities in EKG, Blood Pressure, Expired gas analysis

RHR = Resting heart rate

Peak METS = Peak measured oxygen consumption (ml/kg/min) ÷ 3.5

XRx = Heart rate for exercise prescription

warm-up was followed by a stimulus initially 15 minutes in duration, gradually increasing in two weeks to 30 minutes (equally divided by bicycle ergometer and treadmill modalities). All sessions were followed by a 5 minute cool-down and 10 minute recovery period permitting the patient to return to pre-session electrocardiographic and blood pressure responses. Electrocardiographic signals were telemetered using the Apollo Space Lab Biotel 180 telemetry.

Following three months of conditioning, retesting was performed. Physiological data were compared pre- and post-rehabilitation using the motor-driven treadmill test described. Paired t-test statistics were used to relate pre- and post-rehabilitation data. With these results, the medical consultant and counselor at the Rehabilitation Commission met and discussed the possible return of a client to his previous occupation. If this was not feasible, an attempt to place him in a suitable job or train him in another field was made. The counselors also acted as liason agents in order to assure employers of a client's capabilities.

Results

Comparison of the responses pre- and post-rehabilitation are seen in Table III. All parameters with the exception of those at rest showed significant improvement from first to second testing. Work classification in most patients improved with an increase from light to medium intensity ($p < .01$). Physical working capacity (PWC) at a target heart rate of 130 b/m increased ($p < .01$). Comparison of the pre- and post-values for heart rate and rate-pressure product were made at a fixed workload of 2.0 mph and 10% grade. The mean heart rate changed 7% ($p < .001$ level), representing an improvement in efficiency. Congruent with a heart rate reduction at a comparable workload, the rate-pressure product (heart rate x systolic blood pressure) fell an average of 17% ($p < .001$ level) indicative of decreased myocardial oxygen requirement. The ability of the body to consume oxygen changed an average of 22% ($p < .001$ level). Resting values showed less change. The resting blood pressure change from first to second testing was not satisfactorily significant and resting heart rate remained relatively unchanged.

Results regarding program participation and return to employment are seen in Table IV. Of the 33 patients accepted into the program, 27 (82%) completed the protocol representing a drop-out of 18%. Of the 27 patients completing the program, 24 (89%) returned to full employment following rehabilitation. Return to work for all patients was 27 of 33 (82%).

Table III

Pre- and Post-Conditioning Parameters

	$\bar{X}$	s	t
Work Classification	Pre- 9.6	2.73	3.496*
	Post- 11.6	3.04	
PWC 130	Pre- 5.6	1.33	2.743*
	Post- 6.7	1.32	
Heartrate at Work	Pre- 126	18	3.863**
	Post- 117	12	
Rate Pressure Product	Pre- 20.8	5.02	5.192**
	Post- 17.3	3.94	
VO_2 Maximum	Pre- 26.2	7.22	4.153**
	Post- 31.9	7.91	
Blood Pressure (rest)	Pre- 126/82	12/10	1.869/.816
	Post- 120/80	12/8	
Heartrate (rest)	Pre- 78	10	1.016
	Post- 76	10	

* .01 level
** .001 level

Table IV

Program Participation and Return to Work

	COMPLETED	DROPPED-OUT	TOTAL
PROGRAM	27 (82%)	6 (18%)	33 (100%)
RETURN TO WORK	24 (89%)	3 (50%)	27 (82%)

Discussion

The large financial burden of a heart attack and the high cost of medical care is well known. The American Heart Association (AHA) reports that 1.2 billion dollars are lost annually in wages of those suffering heart attacks. The industrial impact is even greater as a replacement is trained to take over the temporary vacancy. If the patient is unable to meet his former occupational requirements, a valuable human resource is lost and the patient may become an addition to the welfare roster.

To confront the problem of increasing economic impact, disability, and meet the challenge for return to full employment the patient must attain physiological competence for full performance. In this study, competence was attained as reflected by improved physical working capacity, improved cardiac efficiency, decreased MVO_2 requirement and increased total oxygen consumption. Performing more work at a fixed heart rate or equal work at a lower heart rate represents improved cardiac efficiency. The work improvement at a fixed heart rate following a regular conditioning program is in agreement with Cardus and associates (Cardus, Fuentus, Sriniuasan, 1975) who found increased workloads following conditioning with the bicycle ergometer. Cardiac efficiency may improve by increased stroke volume (Hartky, Grimby, Kilbom, et al, 1969) and increased A–V oxygen difference (Saltin, Blomquist, Mitchell, et al, 1968) and improved vascular profusion to those muscles directly involved with the testing activity. Any one or all of these responses could have been instrumental in eliciting the observed results in this study.

A decreased MVO_2 permits the person to do more external work with less internal (cardiac) work. In patients with known angina, the improvement of MVO_2 permits them to perform

tasks more intense and for longer durations before angina becomes a restricting factor. It is known that the MVO_2 is directly effected by heart rate, systolic blood pressure, and ejection time (triple product). It has been documented that the heart rate x systolic blood pressure correlated well with a triple product (Amsterdam, Hughes, DeMaria, et al, 1974). By eliciting a reduction in heart rate or systolic blood pressure, a reduction in MVO_2 occurs. Because of reduced requirement, the myocardium can function effectively while the musculo-skeletal system works more intensely. The results of this study parallel those of other authors (Trap-Jensen and Clausen, 1971; Redwood, Rosing, Epstein, 1972; Detry, Rousseau, Vandenbroueur, et al. 1971).

The improvement of total oxygen consumption in each patient agrees with the literature of Ekblom (Ekblom, Astrand, Saltin, et al, 1968), and Saltin, (Saltin, Blomquist, Mitchell, et al, 1968) and permits the patient to perform work using a smaller percentage of his total aerobic capacity. Recommendations from the AHA Adhoc Committee on Habilitation of the Young Cardiac suggest that when a person is employed full-time, daily tasks should not demand in excess of 50% of his total oxygen consumption capacity. If more than 50% of total capacity is demanded the patient can expect deterioration of the cardiovascular system (Weidman, Blomquist, Brandenburg, et al). The improved capacities in maximum oxygen consumption in these patients contributed to a decrease rather than increase in the percentage of total capacity demanded by a fixed task.

All of these physiological parameters contributed to an improved work classification. Although physiological improvements are encouraging, they only open the possibility of return to employment. Before entry into this study the patients were not physically capable of sustaining full employment in their chosen occupations even though they were three months from infarction and were medically stable. Following conditioning this restriction was removed. The New Jersey State Rehabilitation Commission has experienced an average of 72% return to full employment in its working with people either partially or totally disabled for medical reasons. The finding of the present study reports 89% return to work.

The patients in this study were by design from the lower economic bracket of society. Annually the State of New Jersey reports that 22.8 million dollars are spent to compensate patient disability due to chronic ischemic heart disease. Throughout the nation, the figure soars to 498.4 million dollars for such disability compensation (Lerner, 1975). If the results in this study were only one-half as successful as they actually were, 9 million dollars would be saved annually for the State of New Jersey in funds required to support patients with chronic ischemic disease. Efforts made by the Rehabilitation Commission on behalf of the patient together with convincing patient performance following exercise therapy have produced satisfying results in return to employment. Since the population of cardiac patients is one which demonstrates receptiveness to rehabilitative efforts, it seems appropriate that energy be focused and resources be made available for cardiac rehabilitation.

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More specifically, the objectives of this journal are to promote knowledge and understanding of the unique psychosexual aspects of specific disabling conditions, to enhance better treatment and total rehabilitation of the disabled person, and to provide the health-care practitioner with practical information and guidelines to be integrated in clinical practice. Due to its combined research and clinical emphases, the journal will attract front-line practitioners as well as academicians, researchers, educators and students in medicine, nursing, physical therapy, rehabilitation counseling, social work, occupational therapy and other related professions.

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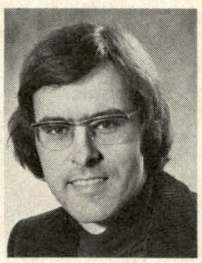

Robert J. Flynn is currently Assistant Professor of Psychology at Indiana-Purdue University, where he teaches in the M.S. program in Rehabilitation Psychology. His major teaching, research, and training interests include normalization and the social integration of the person with a disability; mental retardation and aging; career development and occupational achievement of the person who is disabled; planning and simulation modeling of rehabilitation service systems; and program evaluation. Dr. Flynn received his Ph.D. in Rehabilitation Counselor Education from Syracuse University.

David J. Henderson is the founder of Anthropometrics Heart Clinic in Haddonfield, New Jersey, and presently consults with hospitals and universities throughout the nation. He studied at the College of Wooster, University of Pittsburgh, and Temple University, where his work focused on Cardio-respiratory Physiology. Dr. Henderson devotes his energy to preventive and rehabilitative programs of physical conditioning and education centered around a low-coronary risk life style.

authors' biographies

Donald Orth is a Cardiologist on the staff of West Jersey Hospital, Eastern Division, Voorhees Township, New Jersey; as well as Clinical Assistant Professor in Medicine at the Hospital of the University of Pennsylvania School of Medicine. Dr. Orth attended medical school at the University of Pennsylvania School of Medicine and had his medical and cardiovascular training there as well.

Ami Sha'Ked is presently an Assistant Professor of Psychology at the Purdue University School of Science at Indianapolis. During the academic year 1976–77 he served as the Director of the Rehabilitation Psychology program at Indiana University-Purdue University at Indianapolis. Dr. Sha'Ked was trained as a sex therapist at the Midwest Sexual Counseling Center in Madison, Wisconsin, and participated in seminars conducted by Masters and Johnson at the Reproductive Biology Research Foundation in St. Louis. He was also trained in the area of Sexual Counseling with Physically Disabled at the University of Minnesota School of Medicine. Dr. Sha'Ked is the editor of a new journal, *Sexuality and Disability*. He received his Ph.D. in Rehabilitation Psychology from the University of Wisconsin-Madison.

Jacquelyn Yep is Associate Professor and Extension Specialist at Iowa State University. She is the author of an Extension publication, *Clothes to Fit Your Needs for the Physically Limited,* and has developed and teaches the course, "Clothing in the Rehabilitation Process." Dr. Yep received her Ph.D. from Iowa State University.

Michael Valente is a Certified Rehabilitation Counselor employed by Project with Industry of the Jewish Vocational Service, Chicago since 1973. He completed his M.S. in 1977 at DePaul University's Rehabilitation Services Management Program, and received in 1974, a Commendation from the President's Committee on Hiring the Handicapped, for his organization of a direct placement program at the Advance Transformer Co. in Chicago.

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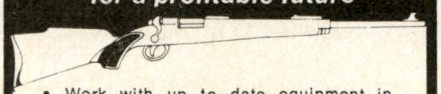

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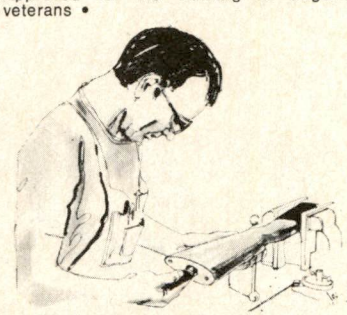

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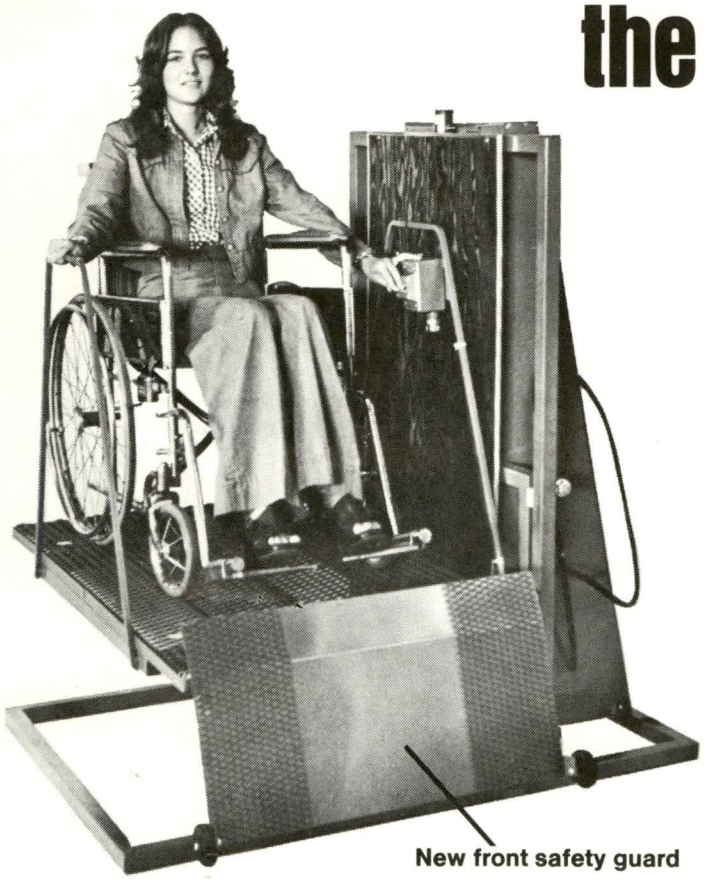

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COUNSELOR CERTIFICATION

What is the purpose of Certification in Rehabilitation Counseling?

The primary purpose of certification is to establish professional standards whereby disabled individuals, related professionals, agency administrators and general public can evaluate the qualifications of persons practicing rehablilitation counseling. Certification has as its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the client's best interests.

How did the certification program develop and how is it organized?

The certification program is a direct outgrowth of the concerns of two professional associtations -- the National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association -- to establish standards and consequently stablize the field of rehablilitation counseling and to provide a baseline for future professional growth. These two associations appointed a joint committee on certification which became an independent incorporated Commission on Rehabilitation Counselor Certification.

The Commission consists of five appointees from NRCA, five appointees from ARCA, three appointees from the American Coalition of Citizens with Disabilities, Inc., and one each from the Council on Rehabilitation Education, Council of State Administrators of Vocational Rehabiliation, Association of Rehabilitation Facilities., National Association of Non-White Rehabilitation Workers, and the National Council on Rehabiliation Education.

Who is eligible to take the Certification Examination?

To be eligible for the Certification Examination, a candidate must meet one of the following requirements of Education and work experience:

- Master's degree in rehabiliatation counseling from an accredited Rehabiliatation counseling edcuation program will not be required to meet a minimum experience requirement. See attached list of accredited schools.

- A Master's degree in Rehabiliatation Counseling from a rehabilitation counselor training program, with a supervisied intership, plus one year of acceptable experience under the supervision of a Certififed Rehabilitation Counselor: or . . .

- A Master's degree in Rehabilitation Counseling without a supervised internship, plus two years of acceptable experience, at least one year of which must be under the supervision of a Certified Rehabilitation Counselor: or. .

- A Master's degree in a related area (such relatedness to be determined by CRCC on the basis of the candidate's transcript), plus two years of acceptable experience, at least one year of which must have been under the supervision of a Certified Rehabilitation Counselor: or . . .

- A Master's dgree in an unrelated area plus five years of acceptable exper-

ience, at least one year of which must have been under the supervision of a Certified Rehabiliation Counselor; or . . .

- A Bachelor's degree in Rehabilitation plus five years of acceptable experience, at least one of which must have been under the supervision of a Certified Rehabilitation Counselor; or . . .

- A Bachelor's degree in any other area plus five years of acceptable experience, at least one year of which must have been under the superivisoin of a Certified Rehabilitation Counselor.

How does the Commission define "Acceptable Experience in Rehabilitation Counseling"?

Employment acceptable to the Commission for a rehabilitation counselor should include:

1. Techniques of counseling special populations and groups;
2. Vocational exploration;
3. Psychological and vocational assessment;
4. Use of social, medical, vocational, psychiatric information;
5. Job placement and or jon developement;
6 Rehbailitative methods in an agency, public or private, business or industry hospital or clinic, in which the applicant is under professional supervision and has employed such methods and measures.

In order for empolyment experience to be conidered acceptable by the Commission, the candidate's job description must contain the first experience component listed above and at least two of the other experience components listed. Experience gained prior to the granting of the Master's degree or Bachelor's degree will be considered only if it had been under the supervision of a Certified Rehabilitation Counselor. Supervision is defined as a systematic and periodic evaluation of the quality of delivery services.

What is the Certification Examination like and how was it developed?

An intensive field-testing process, which spanned a two-year peroid and involved over 8,000 rehabiliatation counselors, educators and administrators has resulted in a pool of examination items statistically validated across levels of education, experience, geography and professional functions and level. Since rehabalilitation counseling is a dyanic and constantly evolving profession, the Commission maintains a Task Force of rehabilitation counseling professionals who continually add to and upgrade this examination item pool.

Each 300-item multiple-choice Certification Examination is drawn from this item pool. Items are practice-based and put a higher premiun on the application of knowledge in serving clients than on isolated bits of factual information. In scoring the examination, maximum credit is given for the "best response" as determined by the item authors and verified by the field-testing process; however, credit may also be given for other responses which may be useful approaches to the problem at hand.

What are the content areas tested by the Certification Examination?

To qualify for certification the candidate is required to demonstrate cometence in the following content areas by achieving a minimum passing score on the Certification Examination as a whole;

A. Rehabilitation philosphy, history, structure and laws.
B. Medical aspects of disability.
c. Psychological aspects of the Handicapping condition.
D. Occupational information and the world of work.
E. Counseloing theory and techniques,
F. Community organization and resources.
G. Placement processes and job developement.
H. Psychology of personal and vocational adjustment
I Evaluation and assestment
J. Ability to utilize research findings and professional publications
K. The delivery of rehabilitation services.

What does Certification cost?

$25.00 Non-refundable processing fee which must be submitted with the Application for Certification.
$50.00 Examination and cerification fee due when an applicant is approved for paticipation in the certification examination.

$75.00 total Certification fee

Where and when is the Certification Examination administratered?

The Certification Examination as presently structured is given twice a year, in the Spring and in the Fall. Barrier-free examination sites are set up for each administration according to the geographical mix of approved candidates to minimize travel expenses for counselors insofar as possible. If a candidate cannot take the examination under ordinary conditions, because of physical limitations or if a candidate wishes to take the examination in Spanish rather than English, special arrangements may be made though the Administrative Office.

What will be the effects of Certification on Rehabilitation Counseling as a profession?

It is not the Commission's intent to certify that any individual is suitable for employment or to impose personnel requirements upon any agency. Rather, the intent is to establish a national professional scale which any interested group, agency or individual may use as a measure. It is hoped that participation by rehabilitation counselors would exercise an increasing influence on the field and ultimately guide legislation, personnel practices, and training programs. Aside from establishing a good measure of professional qualifications for the counselor, certification will futher the public interest and the confidence of other professions and clients. It is evident to date that rehabilitation counselors are encourageing, through their participation in the certification program. a higher level of performance and qualifications that will benefit both the public and the profession.

How does one apply for certification?

All inquiries regarding certification and request for application forms should be directed to the Commission on Rehabilitation Counselor Certification, Suite 1504, 520 North Michigan Avenue, Chicago, Illinois 60611. Our telephone number is (312) 644-4329.

Revised September, 1977

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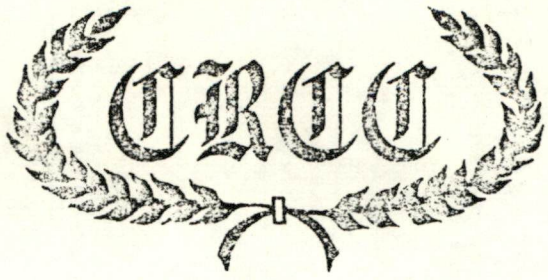
* two year master's program with internship is only portion accredited
** vocational evaluation tract is not accredited



BYLAWS*

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION

Member Organizations

American Coalition of Citizens with Disabilities
American Rehabilitation Counseling Association
Association of Rehabilitation Facilities
Council on Rehabilitation Education
Council of Rehabilitation Counselor Educators
Council of State Administrators for Vocational Rehabilitation
National Association of Non-White Rehabilitation Workers
National Rehabilitation Counseling Association

National Council on Rehabilitation Education

*Adopted December 7, 1973, Chicago, Illinois
Amended June 13, 1975, Chicago, Illinois
Amended June 4, 1976, Chicago, Illinois

ARTICLE I: PURPOSE

This Commission on Rehabilitation Counselor Certification, hereinafter referred to as the "Commission", is organized exclusively for educational and scientific purposes:

A. To establish criteria for the certification of rehabilitation counselors.

B. To conduct programs which will encourage certification and maintain and improve professional standards in rehabilitation counseling.

C. To determine compliance with the criteria for certification.

C. To make available to the public information regarding certification.

E. To assume such other responsibilities, and to conduct such other activities, as are compatible with the operation of a certification program.

No part of the income of the Commission shall be distributable to its members, directors or officers except as permitted by the Non-Profit Corporation Act of the State of Illinois; no member, director or officer of the Commission shall have any right, title or interest in or to any property of any kind owned by it in connection with the performance of its functions nor in or to any income of other funds received by the Commission; no part of the net earnings of the Commission shall inure to the benefit of any private member; no substantial part of the activities of the Commission shall be carrying on propaganda, or otherwise attempting to influence legislation; and the Commission shall not participate in, or intervene in any manner in political campaigns on behalf of any candidate for public office.

ARTICLE II: OFFICES

The Commission shall have and continuously maintain in the State of Illinois an office and registered agent whose office is identical with such registered office. The business office may be within or without the State of Illinois as the Commission may determine.

ARTICLE III: CERTIFICATION PROGRAM

Section 1. Criteria.

The Commission shall establish criteria for the conduct of certification for rehabilitation counseling, which may embody all aspects considered by the Commissioners to be germane to the maintenance of acceptable standards and practice.

Section 2. Procedure.

The Commission shall adopt a uniform evaluation process and a uniform procedure for certification administration.

Section 3. Authority.

The Commission shall have final authority to determine the certification requirements of individuals engaged in the practice of rehabilitation counseling in accordance with the procedures adopted by the Commission.

Section 4. Duration of Certification.

Each certification or re-certification shall be effective until a subsequent action is taken on the certification or re-certification.

Section 5. Revocation of Certification.

Certification may be withdrawn from any previously certified counselor practicing in the field of rehabilitation counseling for cause deemed sufficient by the Commissioners.

Section 6. Appeal.

A practicing rehabilitation counselor who fails to receive initial certification or re-certification, or who has had his/her certification revoked, shall be entitled to appeal in the manner specified in the approved statement of certification procedures.

Section 7. Eligibility.

Requests for certification will be accepted only from counselors who meet the eligibility criteria and standards specified in the approved statement of certification procedures. Applications will be accepted from eligible rehabilitation counselors in the United States, territories thereof, Canada, and United States citizens resident in foreign countries provided arrangements can be made satisfactory to the Commission for the secure administration of the evaluation instrument.

Section 8. Fees.

Certification shall not be contingent upon the payment of any fee other than actual program costs, but certified rehabilitation counselors may be requested to contribute to support the certification program upon the request of the Commission.

ARTICLE IV: MEMBER ORGANIZATIONS

Syction 1. Membership.

The Commission shall be composed of representatives from the National Rehabilitation Counseling Association (NRCA), The American Rehabilitation Counseling Association (ARCA), Council on Rehabilitation Education (CORE), Association of Rehabilitation Facilities (ARF), Council of State Administrators for Vocational Rehabilitation (CSAVR), National Association of Non-White Rehabilitation Workers (NANWRW), and Council of Rehabilitation Counselor Educators (CRCE, as of June 1, 1975). American Coalition of Citizens with Disabilities, Inc. (ACCD, as of December 9, 1976).

Section 2. Additional Members.

Representatives from additional organizations may be admitted to participation in the Commission upon unanimous written approval of all current member organizations, in which case the name of any such additional organization shall be added to Article IV, Section 1, with an indication of the effective date of such participation.

Section 3. Transfer.

Membership in the Commission is not transferrable or assignable.

ARTICLE V: COMMISSIONERS

Section 1. General Powers.

The affairs of the Commission shall be managed by its Board of Commissioners.

Section 2. Representation and Selection of Commissioners.

Each member organization shall have the right to nominate one Commissioner, who shall be affiliated with such member organization, with the exception of NRCA and ARCA which shall have the right to appoint five (5) each, [the majority of which must be practicing counselors at the time of appointment.] The chief salaried officers of NRCA and ARCA shall serve as ex-officio members of the Commission without voting privileges but shall be entitled to attend all meetings of the Commission for the purpose of continuity and facilitating implementation and information regarding certification to the constituent bodies represented by these Associations. Delete

All nominations shall be in writing and executed on behalf of the member organization by its President and his/her designate and delivered to the Commission. The Commission shall retain the right to accept or reject the individuals nominated by the member organizations. Should the Commission reject any such nominee, the appropriate member organization shall be so notified in writing by the Chairman, together with the reasons therefor and a request for other nomination(s).

Section 3. Term of Commissioners.

The term of each Commissioner, other than those Commissioners originally appointed in the Articles of Incorporation, shall be for a period of three (3) years. Upon the expiration of a Commissioner's term, the President of the member organization which he/she represents shall nominate his/her successor to a new three (3) year term.

In the event of death, resignation, inability to act or nonqualification of a Commissioner, the President of the member organization which he/she represents shall nominate his/her successor to serve for the unexpired term.

Commissioners shall be eligible to serve a maximum of two (2) successive terms. At least thirty (30) days prior to the expiration of a Commissioner's term, the member organization shall have delivered to the Commission the name of the new Commissioner nominated by said organization.

When a Commissioner fails to attend two consecutive meetings of the Commission and/or its Committees, a review shall be made by the Executive Committee of the situation and if appropriate a recommendation be made to the Commission that the Commissioner be recalled. Under these circumstances a Commissioner may be recalled by a majority vote of the full Commission. The member organization represented by a recalled Commissioner shall be advised of the recall and a nomination requested for the vacancy so created.

Any member organization which feels its representative is not fulfilling his/her responsibility as a Commissioner has the right to request that the Executive Committee review the Commissioner's performance. If appropriate, a recommendation will be made by the Executive Committee to the full Commission that the Commissioner be recalled. The Executive Committee shall be responsible for reporting to the member organization the recommendation that the Commissioner continue on or be recalled from the Commission. If a vacancy is created by this action, the member organization shall be so advised and a nomination requested to fill the vacancy.

Each Commissioner must be a member in good standing of the member organization by which he/she is nominated during his/her tenure on the Commission.

Section 4. Regular Meetings.

There shall be at least one (1) regular meeting of the Commission each year for the purpose of electing officers and transacting such other business as may come before the meeting.

Section 5. Special Meetings.

Special meetings of the Commission may be called by or at the request of the Chairperson of any three (3) Commissioners upon written request to the Chairperson. The person or persons authorized to call special meetings of the Board may fix any place, either within or without the State of Illinois, as the place for holding any meeting called by them.

Section 6. Notice.

Written notice stating the place, day and hour and the business to be transacted shall be delivered by mail to each Commissioner not less than fifteen (15) days before the date of the meeting. No business shall be transacted at a meeting other than that stated in the notice.

Section 7. Quorum.

A majority of the Commissioners appointed by the member organizations shall constitute a quorum for the transaction of business at any meeting of the Commission, provided, however, that if less than a majority of such Commissioners is present at said meeting, a majority of Commissioners who are present may adjourn the meeting from time to time without further notice.

Section 8. Informal Action.

Any action required to be taken at a meeting of the Commission may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by all the Commissioners.

Section 9. Executive Committee.

The Executive Committee shall be composed of the officers of the Commission and two additional members to be elected by the Commission, one of which must be a consumer.

The Executive Committee shall have and exercise all of the authority of the Commission in the management of its affairs, except as otherwise required by law. Vacancies in the membership of the Committee shall be filled by the Commission at a regular or special meeting of the Commissioners. The Executive Committee shall keep regular minutes of its proceedings and report the same to the Commission when required.

Section 10. Other Committees.

The Chairperson of the Commission may, from time to time, designate two or more Commissioners to constitute one or more special committees to carry out specific mission(s) as outlined by the Chairman. After a special committee's mission has been accomplished, the special committee shall be dissolved.

ARTICLE VI: OFFICERS

Section 1. Officers.

The officers of the Commission shall be a Chairperson, a Vice-Chairperson and a Secretary-Treasurer, and such other officers as the Commission may authorize, all of whom shall be elected from the Commission.

Section 2. Election.

At the regular meeting closest in time to the beginning of each fiscal year on July 1, the Commissioners shall elect officers in the following order: Chairperson, Vice-Chairperson, Secretary-Treasurer, such officers to assume their responsibilities on July 1 of the same year. Elections shall be by secret ballot of all Commissioners present.

Section 3. Term of Office.

Each officer shall hold office for one (1) year and until his/her successor is elected and qualified. The Chairperson may serve a maximum of three (3) consecutive years. Other officers shall be eligible for re-election without limit.

Section 4. Removal.

Any officer may be removed from office by a vote of the majority of the Commissioners in attendance at any regular or special meeting of the Commission.

Section 5. Vacancies.

A vacancy in any office because of death, resignation, removal or incapacity shall be filled in the manner prescribed for the regular election of officers at the meeting of the Commission next following.

Section 6. Chairperson.

The Chairperson shall preside at all meetings of the Commission and may sign on behalf of the Commission all contracts, documents and instruments authorized by the Commission.

Section 7. Vice-Chairperson.

The Vice-Chairperson shall act as Chairperson in the absence or incapacity of the Chairperson, and when so acting shall have all the responsibility, power and authority of the Chairperson.

Section 8. Secretary-Treasurer.

The Secretary-Treasurer shall have charge and custody of and be responsible for all funds and securities of the Commission, see that an adequate accounting system is maintained to give a true and accurate accounting of the financial transactions of the corporation and that reports of such transactions are presented to the Board; and in general perform all duties incident to the office of Secretary-Treasurer. The Secretary-Treasurer shall be the custodian of the Commission records and of the seal of the Commission.

ARTICLE VII: ADMINISTRATION

Section 1. Administrative Management.

The Commission may contract with a qualified corporation to provide administrative and technical services to the Commission. The contracting corporation shall be given authority and shall be held responsible for the coordination and administration of the certification program subject to such policies as may be adopted and such orders as may be issued by the Commission or by limitations stated in these Bylaws.

Section 2. Gifts.

The Commission may accept any grant, contribution, gift, bequest or devise for its general purposes.

Section 3. Indemnity.

Each Commissioner, officer, committee member and other agent of the Commission shall be held harmless and indemnified by the Commission against all claims and liabilities and all costs and expenses, including attorney's fees, reasonably incurred or imposed upon him/her in connection with or resulting from any action, suit or proceeding, or the settlement or compromise thereof, to which he/she may be made a party by reason of any action taken or omitted to be taken by him/her as a Commissioner, officer, committee member or agent of the Commission, in good faith.

This right of indemnification shall inure to such person whether or not he/she is a Commissioner, officer, committee member or agent at the time such liabilities, costs or expenses are imposed or incurred and, in the event of his/her death, shall extend to his/her legal representatives. To the extent available, the Commission shall insure against any potential liability hereunder.

Section 4. Fiscal Year.

The fiscal year of the Commission shall begin on July 1 and end on June 30 of each year.

Section 5. Public Information.

The Bylaws, Statement of Certification Procedures, Criteria for the Counselor Certification Program in Rehabilitation Counseling, list of Certified Rehabilitation Counselors and actions of the Commission regarding certification shall be made available to all. The minutes of the Commission, reports, instruments and other documents shall be held in confidence unless released upon the direction of the Commission.

ARTICLE VIII: LIQUIDATION AND DISSOLUTION

In the event of the liquidation or dissolution of the Commission, whether voluntary or involuntary, the assets of the Commission remaining after payment of its obligations shall have been made or provided for, and which shall not be held upon condition requiring return, transfer, or conveyance, which condition occurs by reason of such dissolution or liquidation, shall be used or distributed exclusively for purposes within those set forth in the Commission's Articles of Incorporation and within the intendment of Section 501(c) (3) of the Internal Revenue Code of 1954 and its Regulations as the same now exist or as they may hereafter be amended from time to time.

ARTICLE IX: AMENDMENT

These Bylaws may be altered, amended or repealed and new Bylaws may be adopted at any meeting of the Commission by a majority vote of the Commissioners present at the meeting.

June 4, 1976

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION
520 North Michigan Avenue - Suite 1504
Chicago, Illinois 60611

APPLICATION FOR CERTIFICATION

Instructions for completing this application are contained in the current *Rehabilitation Counselor Certification: Instructions For Applying*. Please refer to those instructions before proceeding and follow them carefully. If your application is incomplete or any of the required verification is missing, your application will be returned to you.

1. NAME: _____ (Last)

_____ (First) (Middle Initial)

Do Not Write In This Space

2. ADDRESS: _____ (Number and Street)

_____ (City, State, and Zip Code)

Home Telephone ( ) _____

Office Telephone ( ) _____

3. SEX (optional)
1. ☐ Male
2. ☐ Female

4. DATE OF BIRTH

		19
Month	Day	Year

5. SOCIAL SECURITY NUMBER

6. SELF-DESCRIPTION (Optional)
1 ☐ American Indian
2 ☐ Asian-American
3 ☐ Black/Afro-Amer
4 ☐ Caucasian
5 ☐ Chicano/Mexican-American
6 ☐ Puerto Rican/Puerto Rican-Amer
7 ☐ Spanish American
8 ☐ Other _____

7. Because of physical limitations (blindness, disability), special arrangements will be necessary for me to complete the Certification Examination: Yes _____ No _____

Explain: _____

8. I prefer to be examined in English. Yes _____ No _____
I prefer to be examined in Spanish. Yes _____ No _____

9. I have previously applied to this Commission for certification as a rehabilitation counselor: Yes _____ No _____
If yes, give previous identification number. _____

10. Earned Degrees:

	Degree	Major	Institution	Date Degree Awarded
Undergraduate				
Graduate				

Did you graduate from an accredited rehabilitation counseling education program? yes _____ no _____

11. Supervised internship (if Master's degree is in Rehabilitation Counseling from an accredited school):
Name of Site: _____ Supervisor: _____
Dates: _____ Total Number of Supervised Hours: _____
Site Address (city/state) _____

12. Experience Under the Supervision of a Certified Rehabilitation Counselor:
(Account for a minimum of one year)
Name of CRC Supervisor _____
Dates under CRC Supervision _____
Place of your employment when supervised _____
Address _____

HISTORY OF PROFESSIONAL EXPERIENCE

(Continued)

3. Na Employer: mployer: _____

Address: _____ _____

Name of Supervisor _____ Title _____

Dates of Employment: From _____ (Month/Day/Year) to _____ (Month/Day/Year) Total Number of Months _____

Job Title: _____

Detailed Description of Duties: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. N Employer: ployer: _____

Address: _____ Title _____

Name of Supervisor _____

Dates of Employment: From _____ (Month/Day/Year) to _____ (Month/Day/Year) Total Number of Months _____

Job Title: _____

Detailed Description of Duties: _____

_____

_____

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_____

_____

_____

Use additional pages if necessary

Code of Ethics

A rehabilitation counselor has a commitment to the effective functioning of all human beings; his emphasis is on facilitating the functioning or refunctioning of those persons who are at some disadvantage in the struggle to achieve viable goals. While fulfilling this commitment he interacts with many people, programs, institutions, demands, and concepts, and in many different types of relationships. In his endeavors he seeks to enhance the welfare of his clients and of all others whose welfare his professional roles and activities will affect. He recognizes that both action and inaction can be facilitating or debilitating and he accepts the responsibility for his action and inaction.

- The primary obligation of the rehabilitation counselor is to his client. In all relationships he will protect the client's welfare and will diligently seek to assist the client towards his goals.
- The rehabilitation counselor recognizes that the client's family is typically a very important factor in the client's rehabilitation. He will strive to enlist the understanding and involvement of the family as a positive resource in promoting the client's rehabilitation plan and in enhancing his continued effective functioning.
- The rehabilitation counselor is obligated to protect the client-employer relationship by adequately apprising the latter of the client's capabilities and limitations. He will not participate in placing a client in a position that will result in damaging the interests and welfare of either or both the employer and the client.
- The rehabilitation counselor will relate to his colleagues in the profession so as to facilitate their ongoing technical effectiveness as professional persons.
- Typically, the implementation of a rehabilitation plan for a client is a multi-disciplinary effort. The rehabilitation counselor will conduct himself in his interdisciplinary relationship in such a way as to facilitate the contribution of all the specialists involved for maximum benefit of the client and to bring credit to his own profession.
- The rehabilitation counselor will be loyal to the agency that employs him and to the administrators and supervisors who supervise him. He will refrain from speaking, writing, or acting in such a way as to bring discredit on his agency.
- The rehabilitation counselor will regard his professional status as imposing on him the obligation to relate to the community (the public) at levels of responsibility and morality that are higher than are required for persons not classified as "professional." He will use his specialized knowledge, his special abilities, and his leadership position to promote understanding and the general welfare of handicapped persons in the community, and to promote acceptance of the viable concepts of rehabilitation and of rehabilitation counseling.
- In his relationships with other programs, agencies and institutions that will participate in the rehabilitation plan of the client, the rehabilitation counselor will follow procedures and insist on arrangements that will foster maximum mutual facilitation and effectiveness of services for the benefit of the client.
- The rehabilitation counselor is obligated to keep his technical competency at such a level that his clients receive the benefit of the highest quality of services the profession is capable of offering.
- The rehabilitation counselor is obligated to assist in the efforts to expand the knowledge needed to serve handicapped persons with increasing effectiveness.

STATEMENT OF UNDERSTANDING

I hereby apply for Certification to the Commission on Rehabilitation Counselor Certification and ascribe to the Code of Ethics printed on this Application. I understand that Certification depends upon my successfully completing the assessment of competence procedures established by the Commission including submission of all required documents and references and achieving a minimum passing score on the Certification Examination. I also understand that for research and statistical purposes only, data resulting from my participation may be used in an unidentifiable manner.

Signature _____ Date _____

Member Organizations of the Commission are:

American Rehabilitation Counseling Association	ARCA
National Rehabilitation Counseling Association	NRCA
National Council on Rehabilitation Education	NCRE
Council of State Administrators of Vocational Rehabilitation	CSAVR
Association of Rehabilitation Facilities	ARF
Council on Rehabilitation Education	CORE
National Association of Non-White Rehabilitation Workers	NANWRW
American Coalition of Citizens with Disabilities, Inc	ACCD

4/26/77

APPLICATION FOR CERTIFICATION

Code of Ethics

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- The rehabilitation counselor is obligated to assist in the efforts to expand the knowledge needed to serve handicapped persons with increasing effectiveness.

Please mail your completed application with non-refundable processing fee of $15.00 to:

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION
520 North Michigan Avenue - Suite 1504
Chicago, Illinois 60611

STANDARDS AND CRITERIA FOR REHABILITATION COUNSELOR CERTIFICATION

July, 1975

To be eligible to participate in the Certification Examination, a candidate must meet one of the following requirements of EDUCATION combined with EXPERIENCE:

1. A Master's degree in Rehabilitation Counseling from a rehabilitation counselor training program, PLUS a supervised internship, PLUS one year of acceptable experience as defined below.[1]

OR

2. A Master's degree in Rehabilitation Counseling WITHOUT a supervised internship, PLUS two years of acceptable experience as defined below.[1]

OR

3. A Master's degree in a *related* area [2] PLUS two years of acceptable experience as defined below.[1]

OR

4. A Master's degree in an *unrelated* area [2] PLUS five years of acceptable experience as defined below.[1]

OR

5. A Bachelor's degree in Rehabilitation PLUS four years of acceptable experience as defined below.[1]

OR

6. A Bachelor's degree in any other area PLUS five years of acceptable experience as defined below.[1]

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[1]*Acceptable experience in rehabilitation counseling is defined as:* full-time employment acceptable to the Commission in the use of rehabilitive counseling techniques; vocational evaluation; psychological assessment; social, medical, vocational psychiatric information; and rehabilitative methods in an agency (public or private), hospital or clinic, in which the applicant is under professional supervision, and has employed such methods and measures. Effective January 1, 1977, experience submitted as meeting requirements must include at least one year under the supervision of a Certified Rehabilitation Counselor.

[2]The relatedness of a Master's degree to a Master's degree in Rehabilitation Counseling shall be determined by the Commission on the basis of the candidate's transcript.

INFORMATION ABOUT THE CERTIFICATION PROCESS

1. On receipt of your completed application by the Administrative Office of the Commission, you will be assigned a CANDIDATE NUMBER and your application will be acknowledged by postcard.
2. Should your application be postmarked beyond the deadline date for the next Certification Examination as noted elsewhere on this application, your application will be scheduled for review with those received for the following Certification Examination. PLEASE NOTE THAT THE COMMISSION CANNOT BE RESPONSIBLE FOR POST OFFICE DELAYS . . . it is the responsibility of the candidate to ensure delivery to the Commission office.
3. You will receive the following from the Commission when your application has been reviewed:
   a. About 10-12 weeks prior to the Certification Examination, a letter indicating the status of your application, any missing materials or additional information required, appropriate reference forms, and—if your application has been approved—a request for your $30.00 Examination and Certificate Fee and a list of sites where the Certification Examination will be administered.
   b. If your status letter indicated that special review by the Credentials Committee is necessary, you will be advised of the date of the next Credentials Committee meeting. Within one week of that meeting you will be advised of that Committee's decision.
   c. Approximately twenty days before the Certification Examination, an Admissions Pass will be mailed first class to your address of record. You will not be admitted to the Certification Examination without this Admissions Pass.
   d. Within six weeks after the Certification Examination, you will receive your score and a personal profile of your performance in the various content areas. For candidates who have achieved a passing score, a Certificate will be mailed within one month after Examination results have been received.

121 Timber Creek Lane
Silsbee, Texas 77656
November 1, 1977

Mr. Lex Frieden
New Options Research Director
Texas Institute for Rehabilitation
and Research
Texas Medical Center
1333 Moursund Avenue
Houston, Texas 77030

Dear Lex:

Attached please find the article that you requested the members of your committee to work up. I had thought about this article for quite sometime and find it rather difficult to write on this specific topic. In the end I felt that just promulgating the upcoming data pursuant to the certification maintenance program which starts in January seemed to be the most important variable to me. I feel that it is imperative that this certification maintenance data be in the field as soon as possible because the major portion of rehabilitation counselors were certified during the first year of certification. Subsequently, this large segment will need to begin certification maintenance in January of 1978--approximately two months from the writing of this letter. If the majority of these counselors do not interface with the certification maintenance program, I feel that the certification process will suffer significant and irreparable damage.

As you will recognize, the majority of this report is reproduced from the certification maintenance plan. Hopefully, you and Dotty can use this in some way in formulating an article or advise me as to what else you might wish to have pursuant to this endeavor.

Sincerely,

Maunsell

Maunsell Wilkinson, M.S., CRC

MW:cm

cc: Dotty Clifford

REHABILITATION COUNSELOR CERTIFICATION:

INSTRUCTIONS FOR APPLYING

Please read these instructions before completing tha Application for Certification. If your application is incomplete or any of the required vertification is missing, the Application will be returned to you.

A. General Information

STANDARDS AND CITERIA. The Standards and Criteria for Certification listed in "Some Commonly Asked Questions about Rehabiliation Counselor Certification. . ." The basic requirement for education and experience must be met before the date of application. Any application will rejected if submitted before the applicant has met the requirements, and a new application and processing fee will be necessary for re-application after the basic requirements are met.

DEADLINES. Education and experience requirements must be met and applications received by Feburay 1., 1978 for the Certification Examination scheduled for administration April 28, 1978. Applicants received after Feburay 1, 1978 will be considered for the Fall, 1978 Certification Examination. Note: The Commission cannot be responsible for delays in postal service!

FEES. A non-refundable $25.00 application processing fee must accompany the Application for Certification. A $50.00 Examination and Certificate Fee will be required prior to administration of the Certification Examination scheduled for April 28, 1978. The Examination and Certification wil be refuded to applicants unable to sit for the Examination if they notify the Administrative Office prior to April 20, 1978. One deferral from the scheduled examination date is allowed per application. Applicant who deferparticipation until the Fall 1978 Examination and subsequently are unable to sit for that Examination will be required to submit a new Application for Certification and the processing fee.

REFERENCES.Professional references are required at a later time in the application process. On receipt of a completed Application for Certifica tion, the applicant is assigned a candidate number and supplied with appropriate reference forms. References will be required from one supervisor and two peers. It is the responsibility of the applicant to to ensure that these forms are distributed and returned to the Commission .

STATUS. When all reference forms, transcripts, and required vertification have been received, the applicantion will be reviewed as to whether the applicant has met the Standards and Criteria established by the Commission. If approved for participation in the Examination scheduled for administration on April 28, 1978, the candidate for certification will be sent an Orientation Guide for use in preparing for the Examination.

B. Completing the application for Certification, Page 1. The numbered instructions below follow the item numbers of the Form.
NOTE: Application must be typewritten or printed in ink, if illegable application will be returned.

1. Print your name as you want it to appear on your Certificate and in the Registry of Certified Rehabiliatation Counselors.

2. Print the address you wish published in the Registry of C ertified Rehabiliatation Counselors. Telephone numbers are for Commission only.

3-6. Please not that indication of sex and self-description are optional. Your application will not be considered incomplete should you prefer not to supply this information.

7. Please indicate the nature if disability and what special arrangements if any, would be necessary to accommodate you at the testing site.

8. The Certification Examination is availiable only in English and Spanish.

9. Check "yes" only if you have applied perviosly and been assigned an identification number. If you check "yes". please supoly the identification number.

10. In order to verify your deucational beckground, the Commission must receive an official transcript which indicates the granting of the Bachelor's or Master's degee you cite as meeting the education requirements for Certification. The transcript will be considered official only if it bears the seal of the University and signature of the Registrar. If the institution will not release official transcripts to students, the transcripts should be sent directly to the Commission. Your application will be accepted without this official transcript: however, the transcript must be received before your application is reviewed for approval to participate in the Examination.

11. An applicant's professional experience must include at least one year of acceptable experience under the supervision of a Certified Rehabilitation Counselor. It is the responsibility of the candidate to ensure the the Certified Rehabilitation Counselor Supervisor Rating Form is given to the CRC supervisior for submission to the Commission. Should additional rating forms be required, please photocopy the form provided.
NOTE: A graduate from an accredited Rehabilitation Counselor program the one year work experience under a CRC supervisior will not be required.

Application for Certification, Pages 2 and 3: Professional Experience.

Please note carefully the definition of acceptable experience in rehabilitation counseling as stated in "Some Commonly Asked Questions. . ." Should you feel that more information is needed than can be supplied on the application form, please attach job descriptions or a letter of explanation.

A letter from each employer verifying job title, dates of employment, and brief description of job duties must be submitted with the Application for Certification. Employer vertification must be submitted for all employment experiences you cite as meeting the requirements of the Commission. It is your responsibility to contact previousl employers for this vertification. Letters should not be submitted directly to Commission.

Application for Certification, Page 4: Statement of Understanding.

Signing the Certification Application carries with it the acknowledge-

ment that the information contained therein is accurate. If, at a later date, the Commission learns that any Certificate was granted on basis of false or inaccurate information, the Commission reserves the right to suspend or revoke that Certificate.

In addition, signing the Certification Application attests that the candidate subscribes to the Code of Ethics of the Commission on Rehabilitation Counselor Certification as printed on the Application for Certification. The Commission reserves the right to suspend or revoke Certification upon evidence of a violation of this Code of Ethics.

C. Checklist: Before submitting the Application, check and be sure you have:

_____ completed all pats of the Application for Certification.
_____ signed the application form.
_____ enclosed the non-refundable $25.00 application processin fee.
_____ enclosed employer vertification letters for all experience cited as meeting the requirements.
_____ enclosed official transcript or requested institution to send transcript to the Commisssion.
_____ distributed the Certified Rehabilitation Counselor Supervisor Rating Form.

September 1977

CANDIDATE ORIENTATION GUIDE

Commission on Rehabilitation Counselor Certification
520 North Michigan Avenue - Suite 1504
Chicago, Illinois 60611
(312) 644-4329

INTRODUCTION

Certification is a voluntary process established by your peers. Its primary purpose is to establish professional standards whereby consumers of rehabilitation services, related professionals, agency administrators and the general public can evaluate the qualifications of persons practicing rehabilitation counseling. The primary impetus is to provide assurance that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice.

In the early 1960's the membership of professional organizations in rehabilitation counseling began to feel a growing need for standards to be set in the delivery of rehabilitation services. As a direct outgrowth of this concern, two professional associations--the National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association--established a joint committee in 1968 to formulate plans to move toward a certification program. Based upon the recommendations of this Committee, an independent Commission was organized to launch a nationwide certification effort.

The Commission's intent is not to certify that an individual is suitable for employment or to impose personnel requirements upon any agency. The purpose is to establish national professional standards which will assure quality of rehabilitation counseling services to the consumer. It would be hoped that participation by rehabilitation counselors would, over time, exercise an increasing influence on the field and ultimately guide legislation, personnel practices, and training programs. Aside from establishing a good measure of professional qualifications for the counselor, certification will further the public interest and the confidence of other professions and clients.

The Commission on Rehabilitation Counselor Certification, as presently established, has fifteen members, each serving a three year term, nominated by the National Rehabilitation Counseling Association, the American Rehabilitation Counseling Association, the Council on Rehabilitation Education, the Council of State Administrators of Vocational Rehabilitation, the Association of Rehabilitation Facilities, the National Association of Non-White Rehabilitation Workers, and the Council of Rehabilitation Counselor Educators. While CRCC has had one member representing consumers of rehabilitation services since its founding, consumer representation will be increased to three members in 1976.

Ten committees, made up of Commission members and other individuals where appropriate, recommend policies and procedures to the Commission:

Credentials Committee
Appeals Committee
Ethical Practices Committee
Examinations Committee
Finance Committee
Relationships Committee
Certification Maintenance Committee
Candidate Orientation Committee
Research Committee
Standards and Criteria Committee

During 1974-75, the Commission examined the educational and experiential credentials of applicants for certification under the "grandfathering" provision. The 8,008 counselors who met the published Standards and Criteria of the Commission participated in five Field Reviews of potential examination items, assisting CRCC in evaluating their effectiveness and validity. This field-testing process resulted in a pool of examination items proved statistically valid across levels of education, experience, geography, and professional function and level.

Since rehabilitation counseling is a dynamic and constantly evolving profession, the Commission maintains a Task Force of rehabilitation counseling professionals, augmented by consumers and others with special expertise, who continually add to and upgrade this examination item pool. On January 1, 1976, CRCC began its official program of certification by examination.

THE EXAMINATION

One cannot plan to pass any certification examination by cramming during the final few months. Preparation for practice begins in the earliest years of undergraduate study and is a continuous process throughout your advanced academic preparation, internship, and practical work experience. However, an understanding of the rationale and structure of the Certification Examination will make it possible for you to demonstrate clearly your understanding of the professional content of the examination.

The Certification Examination is given twice each year, in the Spring and in the Fall. Barrier free examination sites are set up for each administration according to the geographical mix of applications approved to minimize travel expenses for counselors insofar as possible. If a candidate cannot take the examination under ordinary conditions because of physical limitations, or if a candidate wishes to take the examination in Spanish rather than English, special arrangements may be made through the Administrative Office.

CONTENT

All counselors are required to demonstrate competence in the following content areas by achieving a minimum passing score on the Certification Examination:

- rehabilitation philosophy, history and structure;
- medical and psychosocial aspects of disability;
- occupational information and the world of work;
- counseling theory and techniques;
- community organization and resources;
- placement processes and job development;
- the psychology of personal and vocational adjustment;
- evaluation and assessment;
- the ability to use research findings and professional publications.

Candidates should also be aware of and understand how services are provided in rehabilitation planning, case management, information dissemination, group counseling, and staff development and supervision.

STRUCTURE

Each 300 item multiple-choice Certification Examination is drawn from CRRC's item pool. Items are practice based and put a higher premium on the application of knowledge in serving clients than on isolated bits of factual information. In scoring the examination, maximum credit is given for the "best response" as determined by the item authors and verified by the field testing process. The correct answer should be thought of as the best answer among the alternatives offered--it may or may not be the only indisputably correct answer possible. The multiple-choice items are divided into two sections of 150 questions each. One section is taken in the morning and one in the afternoon. The total time allowed for each section is three hours.

Each question provides information with which to make a choice, and the *one best* answer is to be selected from among the five listed. The questions are designed to help you respond, not by rote, but by assembling information, interpreting data, and solving problems just as you have done in your training and in practice. Every effort is made to keep questions free of traps, tricks, irrelevant detail, disputable points, and ambiguity.

To make scoring more accurate, special answer sheets will be provided to record your responses. Whether or not you have taken a test of this type recently, you should review the notes below:

1. Negative words (not, never, etc.) are used sparingly and are *italicized* for emphasis.
2. Few counseling problems have a single answer that is always correct. Most questions call for the *one best* answer among the choices listed.
3. Time allotments are based on average reading skill, with additional time added, so this is a power rather than a speed test.
4. There is no penalty for guessing, so an attempt should be made to respond to every question.
5. Answer sheets are scored by machine; changed responses should be erased carefully to avoid errors in scoring.

Monitors are always present during the examination to assist candidates as well as to proctor the examination. Needless to say, proctoring includes protecting the security of the examination. ANY CANDIDATE WHO ATTEMPTS TO VIOLATE THIS SECURITY IN ANY MANNER WILL BE DISMISSED FROM THE EXAMINATION AND MAY FORFEIT THE RIGHT OF CERTIFICATION, AT THE DISCRETION OF THE COMMISSION.

CONTENT CLASSIFICATION CHART

Questions are based on five areas which categorize the practice of rehabilitation counseling. The five areas are listed below with subcategories under each major area. Questions are also classified in terms of the mental processes required of the rehabilitation counselor: judgment, problem solving, interpretation of data (problem identification), and recall of factual information. After you review the Content Classification Chart, you may wish to review certain areas before the examination.

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION
CONTENT CLASSIFICATION CHART

I. CLIENT

- A. Child
  - 1. Preadolescent
  - 2. Adolescent (13-18)
- B. Adult
  - 1. Young (19-39)
  - 2. Middle-aged (to-59)
- C. Aged (60+)
- D. General

II. SETTING

- A. Rural
- B. Suburban
- C. Urban
- D. General

III. HANDICAPPING CONDITION

- A. Physical disability
- B. Social deviants
  - 1. Addiction
  - 2. Public offenders
- C. Emotional disorders
- D. Mental retardation
- E. Deaf
- F. Blind
- G. Bicultural
- H. Neurologically impaired (L.D.)
- I. General

IV. KNOWLEDGE REQUIRED

- A. Rehabilitation philosophy, history and structure
- B. Medical and psychosocial aspects of disability
- C. Occupational information and the world of work
- D. Counseling theory
- E. Counseling methods
- F. Community organizations and resources
- G. Psychology of personal and vocational adjustment
- H. Evaluation and assessment
- I. Research utilization

V. SERVICES PROVIDED

- A. Rehabilitation planning
- B. Case management (Coordination)
- C. Information dissemination
- D. Vocational counseling
- E. Personal adjustment counseling
- F. Group counseling
- G. Job development and placement
- H. Vocational and psychological asses
- I. Staff development
- J. Supervision

SAMPLE QUESTIONS

Listed below are five sample multiple-choice questions similar to the ones on the Certification Examination. The best answers and the relationship of the questions to the Content Classification Chart are found on page 9.

1. A 28-year-old male client with an M.A. degree who works as a geological engineer has the beginning stages of multiple sclerosis. He recognizes the potential seriousness of the problem and requests training for his wife so that she can be the breadwinner in case he can no longer work. The counselor should:

    1. test the client's wife to determine her overall ability level.
    2. test the client to determine his interest patterns.
    3. assess the rehabilitation potential of the client.
    4. refuse to work with the client on grounds that he is not feasible for rehabilitation.
    5. provide counseling to both the client and his wife to help them more clearly understand the complexity of the total problem.

2. A 17-year-old male high school senior has done very well in a college preparatory program. He lives on a small farm and had a below-the-elbow amputation of his dominant arm six months ago. Due to trauma, he has experienced severe personal social adjustment problems since the accident and his school performance has been negatively affected. The counselor should:

    1. consider a prevocational evaluation.
    2. discuss means of improving study skills.
    3. contact the school counselor for work on study skills.
    4. determine appropriate colleges to which he might apply.
    5. obtain a psychological evaluation.

3. The client is a 26-year-old female public offender who is just being released from prison. Her past experience was as a cashier but a prospective employer is balking at hiring her because of her record. When meeting with this employer, the counselor should:

    1. tell him that his attitudes are prejudiced and his fears unfounded.
    2. not give the employer background information on the client.
    3. explain to the employer the bonding procedures available to a public offender.
    4. discuss other employer attitudes towards a public offender.
    5. discuss the hardships of prison and the need for this client to have a job.

4. Probably the single most important determining factor in how an individual will adjust to an amputation is the:

   1. site of the amputation.
   2. pre-amputation personality and psychosocial background.
   3. reaction of the individual's spouse and/or family to the amputation.
   4. employability of the individual, especially when compared to the pre-amputation employability.
   5. length of convalescence.

5. A 32-year-old male, a truck driver, is referred to the counselor by the local mental health center. The client has not taken a drink for over eight months and the counselor has located a possible job with a local trucking firm. Before going for the initial job interview, the counselor should:

   1. insure that the client receives continuing treatment at the mental health center.
   2. call the prospective employer and inform him about the clients problem.
   3. advise the client not to tell the employer about his problem.
   4. advise the client to tell the employer of his problem, if necessary and appropriate.
   5. allow the employer to find out about the client's problem on his own.

BEST ANSWERS AND RELATIONSHIP TO

CONTENT CLASSIFICATION CHART

Sample Question	Best Answer	I Client	II Setting	III Handicapping Condition	IV Knowledge Required	V Services Provided
1	5	B_1 Young adult	D General	A Physical disability	G Psychology of personal & vocational adjustment	F Group Counseling
2	5	A_2 Adolescent	A Rural	A Physical disability	B Medical & psychosocial aspects of disability	A Rehab Planning
3	3	B_1 Young adult	D General	B_2 Public offenders	F Community organizations and resources	C Information Dissemination
4	2	D General	D General	A Physical disability	B Medical & psychosocial aspects of disability	E Personal adjustment Counseling
5	4	B_1 Young adult	D General	B_1 Addiction	B Medical & psychosocial aspects of disability	D Vocational Counseling

ou may wish to look again at the sample questions and note how each is related to he content of the examination as shown in the Content Classification Chart. This rocess will perhaps give you guidelines about which areas you wish to review.

RESULTS

You are undoubtedly asking how your passing score on the Certification Examination is determined. As mentioned earlier in this Guide, the Commission has an item pool of approximately 600 statistically validated examination items. Each administration of the examination utilizes different items from that pool. Determination of the passing score *for each administration* is based upon one standard deviation below the statistical mean for the group of examination items selected for that administration.

Within six weeks after the Certification Examination, you will receive notification of your score from the Commission, along with a computer profile indicating your performance in each individual content area as well as on the examination as a whole. Your performance profile is confidential and will be released *only* to you. For candidates who have achieved a passing score, a hand-lettered Certificate will be mailed within one month after examination results have been received.

The Commission is also publishing on September 1, 1976, a Registry of Certified Rehabilitation Counselors. The first issue will contain the names of individuals certified at July 1, 1976. Supplements to this Registry will be issued in September of each year and will add the names of all candidates who have successfully completed the Certification Examination. The Registry is available from the Commission at a cost of $5.00 including postage and handling.

THE DEMOGRAPHIC QUESTIONNAIRE

During the Certification Examination, you will be asked to complete a Demographic Questionnaire made up of about 70 questions about your personal background, education, and work setting. The completion of this Questionnaire is a *requirement* for certification.

The data generated by the Demographic Questionnaire on rehabilitation counselors, supervisors and counselor educators, as well as on their work milieu and certain perceptions held, will have relevance for future research in rehabilitation counseling, counselor education programs, and in service training.

Although your identification as an individual is requested, the Commission is not concerned with your performance on the Questionnaire as an individual. The personal identification serves only to link the characteristics of sets of peopl to sets of responses on the Certification Examination. This information is to be used for research purposes only; your responses will not affect your score on the Certification Examination in any way. However, your completion of the Demographic Questionnaire is critical for achieving the research goals of the Commission on Rehabilitation Counselor Certification.

CERTIFICATION MAINTENANCE

Rehabilitation counselor certification began July 19, 1974 as administrated by the Commission on Rehabilitation Counselor Certification (CRCC), Chicago, Illinois. The CRCC defines the primary purpose of certification to be the establishment of professional standards whereby disabled individuals, related professionals, agency administrators, and the general public can evaluate the qualifications of individuals practicing rehabilitation counseling. Certification has as its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the client's best interest.

The CRCC in 1974 endorsed the principle of certification maintenance. Certification maintenance was developed in the belief that rehabilitation counselors should continue to manifest their competence to deliver quality rehabilitation counseling services to the public.

Certification maintenance begins January 1, 1978. The primary mode of maintenance will be continuing education. Should the Certified Rehabilitation Counselor choose continuing education as the method of Certification Maintenance, 150 contact hours would be required in a period of five years.

The effective date for beginning Certification Maintenance is January 1, 1978. Continuing education completed prior to that date will not be accepted for Certification Maintenance. In order to distribute the work load for administering the Certification Maintenance program, each Certified Rehabilitation Counselor will submit his/her application for Certification Maintenance on the first day of the month in which his/her fifth anniversary of the certification occurs, and each subsequent fifth year

anniversary. The number of contact hours required would be pro-rated as follows:

Date Certified	Deadline for Certification Maintenance	Contact Hours Required
July 19, 1974	July 1, 1979	45
October 15, 1974	October 1, 1979	52 1/2
March 22, 1975	March 1, 1980	65
July 18, 1975	July 1, 1980	75
October 11, 1975	October 1, 1980	82 1/2
April 10, 1976	April 1, 1981	97 1/2
September 17, 1976	September 1, 1981	110
April 23, 1977	April 1, 1982	127 1/2
October 28, 1977	October 1, 1982	142 1/2
After January 1, 1978		150

A Certified Rehabilitation Counselor will have ninety days following the deadline for his/her Certification Maintenance to submit an application. If certification is not maintained, a counselor will not be listed in the Registry of Certified Rehabilitation Counselors, and will be officially notified that he/she may no longer exercise the rights and privileges ascribed to a Certified Rehabilitation Counselor. Reinstatement will be through the regular applicant/examination process under the standards then in force.

The Commission believes that continuing education programs are available in sufficient number and at reasonable or no cost to meet the requirements for Certification Maintenance through continuing education without personal hardship. It was determined that the following sources are examples of continuing education that could be used:

1. Regional Rehabilitation Continuing Education Programs
2. In-Service Education Programs
3. Research and Training Programs
4. College and University Courses
5. Member Organization Approved Programs - Workshops and Seminars

In addition, the Commission recognizes that there may be other programs and alternate forms of continuing education or ways to demonstrate that a counselor has maintained his/her competence in serving clients. The member organizations of the Commission are encouraged to develop alternative plans which would be in the best interest of their members and submit them to the Commission for approval. Such plans should include the relationship between the Commission's plan and the alternative, the monitoring process and the method for evaluation.

Examination

Should the Certified Rehabilitation Counselor be unable to meet the Certification Maintenance requirements through continuing education or an alternative plan developed by a member organization and approved by the Commission, he/she may sit for the certification examination when it is offered during the year prior to his/her deadline for Certification Maintenance.

A counselor electing this alternative must pass the examination at the level of those completing it for initial certification. If the examination is failed, the Commission will consider that the counselor has not maintained his/her certificate and the counselor will not be listed in the Registry of Certified Rehabilitation Counselors, and will be officially notified that he/she may no longer exercise the rights and privileges ascribed to a Certified Rehabilitation Counselor. Reinstatement will be through the regular application/examination process under the standards then in force.

Effective January 1, 1979, one year after certification maintenance begins, all contact hours must be approved in advance in order for the hours to be credited toward maintenance. Prior to January 1, 1979 contact hours need not be approved.

The total fee for certification maintenance is estimated to be $50.00 for services provided the counselor for the succeeding five years. This fee includes annual mailings to certified rehabilitation counselors to disseminate information and verify addresses.

The major portion of this publication is reproduced from the Commission on Rehabilitation Counselor Certification's Plan of Certification Maintenance as adopted in September 11, 1977, as well as from other Commission documents. This article was prepared by Commissioners: Dorothy Clifford, Lex Frieden and Maunsell Wilkinson.

LEX FRIEDEN

Toward a New Professionalism: Certification and Accreditation

Daniel McAlees
Brockman Schumacher

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American Rehabilitation Counseling Association
a division of the American Personnel and Guidance Association

Toward a New Professionalism: Certification and Accreditation

Certification

Daniel C. McAlees, *Chairman*
Commission on Rehabilitation Counselor Certification

What is certification in rehabilitation counseling?

The primary purpose of certification is to establish professional standards whereby disabled individuals, related professionals, agency administrators, and the general public can evaluate the qualifications of persons practicing rehabilitation counseling. Certification has as its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the clients' best interests.

How did certification develop, and how is it organized in rehabilitation?

The certification program is a direct outgrowth of the concern of the two professional associations—American Rehabilitation Counseling Association (ARCA) and National Rehabilitation Counseling Association (NRCA)—to establish standards and consequently stabilize the field of rehabilitation counseling and to provide a baseline for future professional growth. These two associations appointed a joint committee on certification which became an independent incorporated Commission on Rehabilitation Counselor Certification. The Commission consists of five appointees from ARCA, five appointees from NRCA, and one each from the Council of Rehabilitation Education, Council of State Administrators of Vocational Rehabilitation, International Association of Rehabilitation Facilities, National Association of Non-White Rehabilitation Workers, Council of Rehabilitation Counselor Educators, and a representative from a national consumer organization.

Who is eligible for certification?

Professional rehabilitation counselor certification may be established by:

- graduation with a master's degree from an accredited rehabilitation counseling training program, which includes a supervised internship and one year of acceptable experience in rehabilitation counseling;
- attainment of a master's degree in rehabilitation counseling, not including a supervised internship, or a master's degree in a related area (as defined by the Commission) along with two years experience in rehabilitation counseling;
- attainment of a master's degree equivalency level by (a) graduation with a bachelor's degree in rehabilitation, along with four years of acceptable experience in rehabilitation counseling or (b) graduation with a bachelor's degree, along with five years of acceptable experience in rehabilitation counseling.

"Grandfathering" those members who meet the above criteria will be carried out until July 1975. Membership in ARCA, NRCA, and/or an allied professional association will be a prerequisite for "grandfathering." After July 1975, all persons who qualify for certification will be required to demonstrate competence in the following content areas on a certification examination: (a) rehabilitation philosophy, history, and structure; (b) medical aspects of disability; (c) psychosocial aspects of disability; (d) occupational information and the world of work; (e) counseling theory and techniques; (f) community organization and resources; (g) placement processes and job development; (h) the psychology of personal and vocational adjustment; (i) evaluation and assessment; (j) the ability to use research findings and professional publications.

What are specific features of the certification program?

The main features include (a) a commission broadly representative of the entire field of rehabilitation; (b) participation in the development of a certification examination by all present members of the profession who apply for grandfathering; (c) the use of supervisor and peer evaluations to supplement examination data; and, most importantly, (d) the establishment of minimum standards for practice as a rehabilitation counselor.

What is grandfathering?

Those persons currently working in the profession who meet the minimum educational, experiential, and professional affiliation standards outlined above will not be required to demonstrate competence on a

certification examination. They will be required, however, to take the examination for field review purposes.

How do I apply for certification?

All inquiries regarding certification and requests for application forms should be directed to the Commission on Rehabilitation Counselor Certification, 520 North Michigan Avenue, Suite 1504, Chicago, Illinois 60611; telephone—(312) 644-4329.

Please discuss the examination—what is it? how do I prepare for it? and where do I take it?

The examination is a practice-based examination; therefore, it is not necessary for an individual to do a great deal of studying prior to the examination. In fact, intensive study may not help a person pass this kind of examination. Items included in the examination put a higher premium on the application of knowledge in managing clients rather than on isolated bits of factual information.

The first field review was held on 19 July 1974 at 40 sites, and the second on 15 October 1974 at 21 sites. The third field review will be held 22 March 1975. The primary site for this field review will be New York City in conjunction with the annual ARCA-APGA meeting.

Two additional field reviews have been scheduled: one on 18 July 1975 (deadline for applications, 1 April 1975) and one on 12 October 1975 (deadline for applications 1 July 1975). Sites for these field reviews will be selected based on the location of the applicants. Any geographical or organizational entity of rehabilitation counselors may determine the most appropriate site for administering the field review within their area. When twenty or more counselors can be brought together under the conditions set by the Commission for the field review, the Commission will administer the examination at the site requested. A checklist detailing criteria for site selection is available on request. If you would like to arrange for a site in your area, please contact the Commission office.

The field review will be available in a Spanish translation, and the Commission will provide equal access and opportunity to participate to all disabled counselors who apply.

What will certification cost me?

The total fee for certification during the grandfather period is $45. Fifteen dollars of this total fee should be sent with the completed application. When approved, you will be assigned to a field review site and requested to send the remaining $30 of this fee. These fees reflect the total cost for certification and no additional fees will be assessed for annual renewal of the certification certificate.

What will be the effects of certification on rehabilitation counseling as a profession?

The intent is not to certify that any individual is suitable for employment or attempt to impose personnel requirements upon any agency; the intent is to establish a national professional scale which any interested group, agency, or individual may use as a measure. It would be hoped that voluntary cooperation by a majority of rehabilitation counselors would, over time, exercise an increasing influence on the field and ultimately guide legislation, personnel practices, and training programs. Aside from establishing a good measure of professional qualifications for the counselor, certification will further the public interest and the confidence of other professions and clients.

To date, more than 5,000 rehabilitation counseling professionals have made application to participate in the certification program, an overwhelming and revealing response. It is evident that rehabilitation counselors are encouraging, through certification, a higher level of performance and qualifications that will benefit both the public and the profession.

Accreditation

Brockman Schumacher, *President*
Council on Rehabilitation Education (CORE)

What is accreditation?

Since the United States has no federal ministry of education, the responsibility to ensure quality training programs for practicing professionals rests with individual states, educational institutions, and professional organizations. Thus, accreditation is concerned with the quality of educational programs in certain institutions and professions. This process entails nongovernmental self-evaluation of training within a professional discipline. It serves to identify acceptable levels of training so as to maintain high standards and to establish goals for self-improvement in professional education.

Is there any relationship between accreditation and certification?

Although both accreditation and certification are assessment processes, there is no formal or procedural relationship between the two. However, both these processes are concerned with evaluation and improvement of

professional practice and, therefore, they are parallel in nature. Constant dialogue concerning issues, criteria, objectives, and goals is necessary to deal with ongoing, crucial matters associated with a profession.

How did accreditation develop in rehabilitation counseling?

In 1970, leadership from the American Rehabilitation Counseling Association (ARCA), the National Rehabilitation Counseling Association (NRCA), the Council of Rehabilitation Counselor Educators, the Council of State Administrators of Vocational Rehabilitation, and the International Association of Rehabilitation Facilities recommended establishing a planning committee to address itself to the issues of accreditation. This planning committee became incorporated and developed strategies for the accreditation process. These strategies included procedures, instruments, and standards, which received approval of the National Commission on Accrediting.

Presently the Council on Rehabilitation Education (CORE) is composed of two representatives from each of the participating professional rehabilitation organizations. CORE's major responsibility now is the implementation of the accreditation process, program assistance, and development.

What are the features of the CORE approach to accreditation?

The major emphasis of CORE's approach to accreditation is on program development and improvement, rather than mere formal approval. During the pilot phase of developing the accreditation process, site visits were used as a basis for evaluation. These have now been replaced by a systematic, research-based collection of data on a particular training program, although site visits may be used as supplemental sources of data when needed. The data include both a review of the training program itself and employer evaluation of the program's graduates. The accreditation process also stresses continued reevaluation of its methods, criteria, and standards.

How does a training program become accredited?

A training program must meet initial eligibility criteria and be evaluated and approved by CORE's Commission on Standards and Accreditation.

What is expected from a program undergoing the accreditation process?

The faculty is expected to carefully complete a Program Evaluation Self-Report Schedule, which reviews curriculum, faculty, and students. Cooperation in supplying further information or collecting more data for the Commission is essential. Successful implementation of specific recommendations for improving a program's standards is also expected.

What advantages are there to a program's being accredited?

The major advantages in accreditation are to ensure self-evaluation and to assist in the improvement of preparation programs for rehabilitation counselors. The achievement and maintenance of quality in preparation programs accrue special advantages to consumers—applicants, students, graduates, employers, and the general public. Publication of a program's mission and status among other programs in the country lead to the knowledge of its standing in relation to accepted professional criteria of preparation in rehabilitation counseling.

What does it cost?

A fee of five hundred dollars is charged for the accreditation year or initial participation in the process. In order to sustain accreditation, the program must continue contact with the Commission yearly. A fee of two hundred dollars is charged for this continued support.

The individual program must bear the cost of accreditation and any additional expenses, if a site visit is necessary. In the case of providing assistance in program development, CORE has a separate fee schedule.

How often does a program need to be reevaluated?

Reevaluation for continued accreditation must occur every five years. In some instances, special conditions will be set which might make accreditation more frequent.

What is the value of accreditation to the profession of rehabilitation counseling?

The basic purpose of accreditation is to assure quality education of rehabilitation counselors, thereby promoting the effective delivery of vocational rehabilitation services to persons with handicaps. The accreditation procedure will promote program self-improvement as a regular system. Accreditation will assist in placing rehabilitation counseling on a par with other professional disciplines. Finally, and most importantly, such procedures ensure a level of excellence in professional training with the ultimate goal of improving service delivery to rehabilitation clients.

Some commonly asked questions about Rehabilitation Counselor Certification...

WHAT IS THE PURPOSE OF CERTIFICATION IN REHABILITATION COUNSELING?

The primary purpose of certification is to establish professional standards whereby disabled individuals, related professionals, agency administrators and the general public can evaluate the qualifications of persons practicing rehabilitation counseling. Certification has as its primary impetus the provision of assurances that professionals engaged in rehabilitation counseling will meet acceptable standards of quality in practice. Such standards are considered to be in the clients' best interests.

HOW DID THE CERTIFICATION PROGRAM DEVELOP AND HOW IS IT ORGANIZED?

The certification program is a direct outgrowth of the concern of two professional associations — the National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association — to establish standards and consequently stabilize the field of rehabilitation counseling and to provide a baseline for future professional growth. These two associations appointed a joint committee on certification which became an independent incorporated Commission on Rehabilitation Counselor Certification.

The Commission consists of five appointees from NRCA, five appointees from ARCA, and one each from the Council on Rehabilitation Education, Council of State Administrators of Vocational Rehabilitation, Association of Rehabilitation Facilities, National Association of Non-White Rehabilitation Workers, Council of Rehabilitation Counselor Educators, and a national consumer representative.

WHO IS ELIGIBLE TO TAKE THE CERTIFICATION EXAMINATION?

To be eligible for the Certification Examination, a candidate must meet one of the following requirements of *education* combined with *experience*:

- A Master's degree in Rehabilitation Counseling from a rehabilitation counselor training program, *plus* a supervised internship, *plus* one year of acceptable experience as defined below; *or*. . .
- A Master's degree in Rehabilitation Counseling *without* a supervised internship, *plus* two years of acceptable experience as defined below; *or*. . .
- A Master's degree in a *related* area (such relatedness to be determined by CRCC on the basis of the candidate's transcript), *plus* two years of acceptable experience as defined below; *or*. . .
- A Master's degree in an unrelated area *plus* five years of acceptable experience as defined below; *or* . . .
- A Bachelor's degree in Rehabilitation *plus* four years of acceptable experience as defined below; *or*. . .
- A Bachelor's degree in any other area *plus* five years of acceptable experience as defined below.

HOW DOES THE COMMISSION DEFINE "ACCEPTABLE EXPERIENCE IN REHABILITATION COUNSELING"?

Acceptable experience in rehabilitation counseling is defined as full-time employment acceptable to the Commission in the use of rehabilitative counseling techniques; vocational evaluation; psychological assessment; social, medical, vocational psychiatric information; and rehabilitative methods in an agency (public or private), hospital or clinic, in which the applicant is under professional supervision and has employed such methods and measures. Effective January 1, 1977, experience submitted as meeting certification requirements must include at least one year under the supervision of a Certified Rehabilitation Counselor. Questions concerning the acceptability of an individual's experience are considered on a case-by-case basis by the Commission's Credentials Committee.

WHAT IS THE CERTIFICATION EXAMINATION LIKE AND HOW WAS IT DEVELOPED?

An intensive field-testing process, which spanned a two-year period and involved over 8,000 rehabilitation counselors, educators and administrators, has resulted in a pool of examination items proved statistically valid across levels of education, experience, geography and professional function and level. Since rehabilitation counseling is a dynamic and constantly evolving profession, the Commission maintains a Task Force of rehabilitation counseling professionals who continually add to and upgrade this examination item pool.

Each 300-item multiple-choice Certification Examination is drawn from this item pool. Items are practice-based and put a higher premium on the application of knowledge in serving clients than on isolated bits of factual information. In scoring the examination, maximum credit is given for the "best response" as determined by the item authors and verified by the field-testing process; however, credit may also be given for other responses which may be useful approaches to the problem at hand.

WHAT ARE THE CONTENT AREAS TESTED BY THE CERTIFICATION EXAMINATION?

All persons who qualify for certification are required to demonstrate competence in the following content areas by achieving a minimum passing score on the Certification Examination:

- rehabilitation philosophy, history and structure;
- medical and psychosocial aspects of disability;
- occupational information and the world of work;
- counseling theory and techniques;
- community organization and resources;
- placement processes and job development;
- the psychology of personal and vocational adjustment;
- evaluation and assessment;
- the ability to use research findings and professional publications.

WHAT DOES CERTIFICATION COST?

To 12/31/76	Effective 1/1/77	
$ 15.00	$ 25.00	Nonrefundable processing fee which must be sent with your application form.
$ 30.00	$ 50.00	Examination and Certificate Fee due when your application is approved for participation in the Certification Examination.
$ 45.00	$ 75.00	Total Certification Fee.

WHEN AND WHERE IS THE CERTIFICATION EXAMINATION ADMINISTERED?

The Certification Examination as presently structured is given twice each year, in the Spring and in the Fall. Barrier-free examination sites are set up for each administration according to the geographical mix of applications approved to minimize travel expenses for counselors insofar as possible. If a candidate because of physical limitations cannot take the examination under ordinary conditions, or if a candidate wishes to take the examination in Spanish rather than English, special arrangements may be made through the Administrative Office.

WHAT WILL BE THE EFFECTS OF CERTIFICATION ON REHABILITATION COUNSELING AS A PROFESSION?

The Commission's intent is not to certify that any individual is suitable for employment or to impose personnel requirements upon any agency, but to establish a national professional scale which any interested group, agency or individual may use as a measure. It would be hoped that participation by rehabilitation counselors would, over time, exercise an increasing influence on the field and ultimately guide legislation, personnel practices, and training programs. Aside from establishing a good measure of professional qualifications for the counselor, certification will further the public interest and the confidence of other professions and clients. It is evident to date that rehabilitation counselors are encouraging, through their participation in the certification program, a higher level of performance and qualifications that will benefit both the public and the profession.

HOW DOES ONE APPLY FOR CERTIFICATION?

All inquiries regarding certification and requests for application forms should be directed to the Commission on Rehabilitation Counselor Certification, Suite 1504, 520 North Michigan Avenue, Chicago, Illinois 60611. Our telephone number is (312) 644-4329.

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