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PRELIMINARY REPORT ON "NEW OPTIONS TRANSITIONAL PROJECT"

The following report is based upon several sight visits to the New Options program as well as printed material provided by the program. In some cases it represents my impressions of what is involved in the program more than it represents the written material that was provided to me. Also, while this report attempts to provide information regarding the full scope of the program, it is, nevertheless, a summary sort of statement, and as such it contains various oversimplifications.

Nature of the program

The New Options Transitional Project is a program that has been designed to determine successful methods for providing re-entry into mainstream society for severely disabled persons. It is directly concerned with helping severely physically disabled persons to acquire skills that will facilitate such re-integration. As part of this integration, the program attempts to establish or create the basis for independent living, educational and vocational involvement, and active social participation in the mainstream of society. The program involves ongoing assessment and counseling, training, modules, structured contacts with active handicapped individuals in the Houston area, and strengthening of self-dependent skills.

Personnel

The core staff includes the following: Jean Cole, Ph.D., Project Director; Lex Freiden, Research Director; Jane Sperry, Functional Skills Advisor & Program Coordinator; Linda Lavinson, Social Worker; and various attendants, clerical staff and staff associates.

Goals and objectives

There are two general categories of goals involved in this program. One set of them involves the attempts to discover efficient and successful means for providing services that will benefit the participants (the disabled persons going through the program). These goals include such things as improving the way the program itself is administered, what the modules consist of, and how information is imparted.

The second set of goals involve the participants themselves and the hoped for outcomes of the program. These goals (some of which are indicated above) involve severely disabled persons becoming socially functional and independent. It is intended that those leaving the program have developed the necessary knowledge and goals to be able to re-integrate in mainstream society.

Sponsorship and funding

This is a pilot project sponsored by the Texas Institute for Rehabilitation and Research (TIRR), Houston, Texas. Funding sources include research money from TIRR and per-diem funds for each participant from the Texas Rehabilitation Commission (TRC), but the primary funding source is a Research and Demonstration grant from the Rehabilitation Services Acministration of the Department of Health, Education and Welfare.

Facility

A wing of the TIRR annex, located at 105 Drew Street, Houston, Texas 77006, is used to house the program. The core staff all maintains offices at this location, and the participants live in individual rooms provided at this location.

Participants

Participants accepted to this program are severely disabled persons who have heretofor had difficulty in integrating into the mainstream of society. Generally, this includes persons whose living and social situations have hindered such integration. Examples are severely disabled persons living in nursing homes, family homes, or shut-in circumstances. Participants are all residents of the state of Texas, and they must meet the following eligibility requirements: (a) they must be between the ages of 18 and 50, (b) they must use wheelchairs as their means of mobility, (c) they must be medically stable (i.e., not suffering from acute medical problems), (d) they must be physically capable of being up and active at least 8 hours a day, and (e) they must be able to communicate verbally with relative ease. In addition, the participants are generally people who have been disabled for at least two years, and often longer.

Handicapped persons become participants in this program through a process of application and referral. The primary source of applications and referrals is TRC. As a result, most participants are sponsored by TRC.

The average number of participants in each cycle is eight.

Structure and function

The program is described as consisting of the following elements: (a) a residential support system, (b) ongoing assessment and consultation, (c) contacts with active handicapped persons in the community, (d) field trips, (e) individual practice activities, (f) family group meetings, and (g) training modules.

The program involves a six week stay at a residential facility where meals, transportation, sleeping quarters and attendant care are provided. Every six or seven weeks a new cycle begins with a new group of participants arriving at the TIRR Annex. During the six week cycle, the participants are involved in the assessment and consultation, the contacts with disabled persons from the Houston area (both at the Annex and at various locations around Houston), the practice activities (e.g., practicing to use

a washing machine), the field trips (to the homes of active disabled persons, to shopping centers, to the University of Houston, and so on), and the training modules.

The core of the program is contained in the thirteen training modules. Participants attend these modules either at the facility itself or through field trips into the community. Each module will meet at least once during a six week cycle, and generally they meet more often (e.g., once a week) at scheduled times. The following is a list of the training modules with a brief description of what is contained in each:

(1) Attendant Management Module--locating, hiring and working with physical attendants (these are persons who are employed by the severely disabled for assistance in such things as getting in and out of bed, getting dressed or undressed, going to the bathroom, and so on).

(2) Financial Management Module--information regarding the availability and use of public funds (e.g., from TRC), eligibility regquirments, budgeting, using bank accounts, and credit buying.

(3) Consumer Affairs Module--addresses issues of public transportation, architectural barriers, availability of accessible housing, and so on.

(4) Mobility Module--accessible vehicles, lifts, driving controls and drivers' training, use of public transportation.

(5) Educational Opportunities Module--types of vocational training available, accessible colleges and universities, visit to the University of Houston, applications and interviews, planning an educational program.

(6) Vocational Opportunities Module--discussion of the range of employment available along with job-seeking skills and strategies.

(7) Home Management Module--adaptive techniques of housekeeping.

(8) Medical Needs Module--self-directed care, resources in the community, routine medical maintenance, emergency care plans, medications.

(9) Living Arrangements Module--various individual and/or group living situations, accessible residential structures, architectural modifications, financial assistance.

(10) Social Skills Module--communications techniques and exploration of feeling (particularly in connection with social situations).

(11) Leisure Time Module--spectator activities, participant activities, swimming, hobbies, travel.

(12) Functional Skills Module--creative alternatives for daily living.

(13) Sexuality Module--sexuality in the disabled, dating, role expectations.

Preliminary analysis

After several visits to the project, reading over the literature describing it and observing a couple of modules in operation, I can offer some analysis of the program and my reactions to it. From the foregoing, it may be apparent that there are many facets to this program, and it is possible to appoach it in many various ways and with various points of focus. Clearly, the focus and approach I will present here will not be the only ones that could profitably be employed, and they reflect my personal biases and interests.

First, to me it is readily apparent that the model for this program is an educational one. That is, the program is geared to provide educational experiences for the participants, primarily by conveying information. These educational experiences, particularly the material that may be learned in them (i.e., what is learned from the modules), are all intended to provide the basis for successful re-integration into mainstream society.

It appears to me that this approach was adopted, because standard programs and procedures of medical and physical rehabilitation are seen as not providing such information. At the same time, standard rehabilitation is seens as not including concept of or means for a gradual transition into mainstream society. This program is intended to fill an existing gap in the process of rehabilitation, specifically a gap in providing necessary information and a gap in supplying a means for gradual transition.

It further appears that a major assumption is that the provision of such information and means for transition are effective ways to establish re-integration in mainstream society. The further intent of this project is to test out this assumption, including the discovery and demonstration of successful ways to fill the perceived gap in rehabilitation. Implied in this approach is a view toward the participants which sees them as lacking in opportunities and information, rather than lacking in psychological adjustment. Or if there is a failure in adjustment, it is seen as a result of failures in the environment rather than failure within the disabled person's personality. A severely disabled person may appear to lack motivation and may seem poorly adjusted, but this may arise from a failure to provide sufficient opportunities and environmental stimulation.

While the foregoing is not necessarily expressed in such terms in the literature provided by the program, it seems to me to be an underlying aspect of it. The project attempts to assess whether or not it is the case that providing new options, further information, and a basis for gradual re-entry will result in more severely disabled persons successfully functionting in mainstream society. In the end, this appears to me to be the most basic goal: to increase the number of fully functioning, severely disabled persons in society; the project is a pilot program attempting to locate ways in which to bring this about.

A second majore aspect of the program is its attempt to move from the passive mode of the medical model of rehabilitation to a much more active mode. That is, standard rehabilitation programs are seen as placing the rehabilitant in a passive position of simply receiving medical and physical services. While this may indeed be necessary during the early phases of rehabilitation, a time when the newly disabled person must receive attention in dealing with the physical causes of the disability and the regaining of whatever physical functioning may be available subsequent to disablement, successful re-integration is seen as requiring the development of increasingly active modes of response. In other words, the newly disabled person may at first need to passively turn him- or herself over to the ministrations of the medical staff, but eventually he or she wil need to assume active role functioning in society and in self-care as part of adjusting to the disability.

Targets for consultation

It should be apparent from the preceding that this program has much to offer. Probably its greatest strength is its attempt to foster active involvement (a move from passive, shut-in responses exhibited by participants prior to admission to the program) and encourage self-dependence.

In my view, the single greatest weakness of the program is that it does not go far enough in this direction. It seems to me that the educational mode is one that further encourages a passive-receptive sort of response. The participants aren't required to do any more than to listen, observe, and "soak up" the material presented. Poor attendance at the modules is an indication of how the participants may slip into passive and nonresponsive modes. I am told that in fact attendance does gradually fall off after initial enthusiasm.

It is my feeling that some alterations in the program might successfully shift the participants into the program. My preliminary suggestions include the following:

(1) Changes in presentation of material from the outset emphasizing that this is all intended to lead to active, self-dependent reintegration in mainstream society. This could include a statement during the orientation session at the beginning of each cycle conveying the fact that the program is the first step toward independence, not just a rehearsal. This message might be repeated throughout the program.

(2) Programmatic changes in how the modules and the cycle in general is conducted. For example, I suggest that instead of just providing information regarding obtaining and using attendants, participants be required to discover and make provisions to use the available staff on their own. Upon arrival, participants could be informed that attendants are available, but they must find out who they are on their own, as well as arrange to use them.

SYSTEMS ASSESSMENT OF THE NEW OPTIONS PROJECT

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BACKGROUND

The New Options program is designed to serve individuals who have had difficulty in adapting to community living after leaving hospital based rehabilitation programs. It offers three interrelated types of experiences to its participants: (1) It provides specific information about various aspects of disability and community living; (2) it provides individual counseling to assist in problem identification and personal adjustment, and (3) it provides a series of experiences in community settings and with successfully functioning, physically disabled people so that expectations about what is possible are changed.

The effectiveness of the New Options program is monitored by an ongoing research effort. The major thrust of this effort is to assess changes in participant's community functioning which might be attributable to the program. This is done by looking at community activity levels before and after entry into the program. At the same time there has been an interest in monitoring the New Options system itself; that is, to look at how the program functions, what its treatment philosophy is and how well the philosophy is expressed in practice. The consultation project reported here was commissioned to assist in this task.

STRUCTURE

The New Options program is currently organized into a series of modules which take place over a six week period. Each module deals with a specific content area such as financial management, sexuality, medical needs, and so on. Some modules are run by regular staff members and others are run by community consultants, that is, physically disabled individuals from the community who have special knowledge or experience to offer. Some modules combine both staff

and consultants as leaders. Each module offers a series of experiences such as lectures, group discussions, expert panels, field trips, and exercises. Some modules, such as medical or financial planning have a high information content while others, such as mobility or social skills have a high experiential component.

PROBLEM

Several issues surfaced during the consultation. The first was how to assess the effectiveness of the individual modules. It quickly became apparent that this was a more difficult problem than assessing the impact of the program as a whole which can easily be conceptulized as a pre-test, post-test design which looks at how participants function before and after entry into the program. Variables such as contacts with other people, educational or vocational activity, number of different activities performed, time away from home and so forth make sense and are relatively easy to measure. Attitudinal or self-concept measures can likewise be obtained before and after the program. It is not so easy however, to break up the integrated whole and look at the impact of the individual modules on final outcome. Practical restrictions prevent experimentally manipulating the system such as by altering a single module while holding other factors constant. In fact, it is difficult to hold the content of the modules constant from one cycle of participants to another because, as the character and needs of the participants change, so does the content of the program.

The interaction between the types of participants and the nature of the program raised several other issues. The first was the difference between a criterion performance model and an improvement based model. It was clear that partici-

pants vary a great deal in their entry-level skills and needs. It was not so clear whether the program was defining a successful outcome in terms of a specific level of functioning or in terms of some amount of improvement over entry level abilities. A second, and more subtle issue, concerned the way in which program staff conceptualize the functioning of the program. On the one hand there was a concern that some specific items of information be presented to the participants. This was linked to a desire to create a standardized package of module contents which might be distributed to other rehabilitation programs. At the same time, there was a feeling that the program must be individualized to some extent. There was also a feeling that much of the impact of the program results from changed expectations about what is possible for a disabled person, caused by contact with the successfully rehabilitated community consultants, rather than from exposure to specific information about disability. The role of the counseling was also not clear: it was considered important, but its place in relation to the rest of the program and ways of assessing its impact were uncertain. Finally, the importance of free-time and informal contacts with the staff members was raised. It was generally agreed that the availability of at least one staff member for informal contacts with participants was desirable but no such staff role or time had been formally designated. Instead this role had simply appeared as a function of the personality of certain staff members and the needs of the participants. Discussion of why this role was important led to an increased awareness on the part of the consultant that informal, non-specific contacts represent an important part of what the New Options program offers.

ALTERNATIVE MODELS

All of the above issues may be conceptualized under a general comparison of

educational, clinical, and theraputic community models of program functioning. The actual functioning of the New Options program represents a mixture of these approaches: (1) The module structure of the program derives from an educational orientation. The breakdown of the program experience into content areas which are operated separately by staff or community consultants assumes a specialized skill or body of knowledge which is to be transmitted in each module. (2) The clinical model is represented by the counseling relationships offered by various staff members: some around vocational needs, others around personal adjustment or functional performance needs. (3) Finally, the theraputic community concept is expressed in the modeling done by the community consultants, and the field trips to community settings where skills are tried out and actual adjustment issues raised.

The relative importance of these three orientations is the operation of the program is not clear. The program has not been conceptualized in these terms but instead grew into its present form on the basis of the experiences of the staff in working with successful and unsuccessfully rehabilitated people. Many of the field trips included in the modules were included because community consultants or staff had experienced difficulties with certain settings in the past and had had to find ways to overcome them. This experiential-based concept attempts to provide a series of hands-on experiences which provide not only a set of skills but an altered perception of personal functioning and relationship with the world.

The mixture of models used in the operation of the program has some strengths

in that a variety of needs are being met. The weakness has been that an understanding of the purpose and functioning of the program has been obscured. Staff have been operating on a set of individual, implicit assumptions about the program. This has been possible because so many different functions are being performed. The difficulty has been in locating inefficiencies or blank spots in the operation of the system. From the consultants point of view, there was considerable duplication across some of the modules and there were some important things that were not given sufficient program recognition. Most importantly, it seemed that the goal of individualizing the process was not being adequately met at the program level although it was being dealt with in some of the individual modules.

ASSESSMENT

The assessment effort was originally focused on the module structure and an attempt was made to create measurement techniques for each module. It was clear, however, that the impact of the individual modules on the final outcome could not be measured; instead, the functioning of the modules would have to be assessed in terms of knowledge and skills the participants receive as they go through the system. The content of the modules is based on simple face validity, i.e., it is based on what the staff feels is important for a disabled person to know and those things he should be able to do. Whether or not disabled people do indeed need the information or skills offered is more a matter of the definition of successful rehabilitation than it is of validation. During the consultation, it became clear that there was considerable agreement among the staff about the importance of various parts of the program. Nevertheless, the consultant had the feeling

that the rationale was more covert than explicit. One of the goals for the consultant, therefore, was to use the assessment task to bring the thinking of the staff more into the open, so that it might be rationally structured.

The modules differ considerably in the mix of counseling, information and experiential activities and the assessment techniques for each of these also differ. Information content is conceptually the easiest to measure: staff were asked to provide true-false, multiple choice or essay type questions to cover the information content. A problem that arose with this, however, was that the information content apparently shifts from cycle to cycle and has never been formally written down for any module. It thus became clear that what is taught in the modules depends to a great extent on the current module leader rather than on some centralized planning decisions. The issue of whether this is desirable or not was not resolved during the consultation. There was discussion of using videotape to standardize certain presentations but this was felt to conflict with the personal contact obtained when community consultants made the presentations.

A second approach to assessing the information content of a module is to design specific tasks such as creating a budget in the financial module; or listing medical information relevant to the participant in the medical module. This work-sample approach provides a straight forward measure of skills learned.

The counseling functions of certain modules proved to be difficult to assess just as they are in other formats such as psychotherapy or vocational counseling. The purpose of the couseling is to increase the participants awareness of goals and options. Given this, it was recommended that participants list short and long term goals appropriate to each module both before entering and just before finishing the module. The assumption being, that if the module is effection, the number of goals seen as possible will expand and goals will become more realistic and detailed. A part of this exercise would include listing the steps necessary to obtain the goals. This listing task not only serves the purpose of assessing the functioning of the program but provides the module leader with information that can be useful in planning the participant's activities.

The experiential functions of the various modules provide another complex assessment task. The consultant found general agreement among the staff that the field trips and activities which occur on the field trips are a key part of the program; but again, these had never been explicitly written down. Instead, program leaders had created a series of events, such as a trip to the airport, which they felt to be important based on their experience and knowledge about the adjustment of physically disabled people. Several anecdotal accounts of exercises designed for a particular participant made it clear that many of these exercises occured to staff during the course of a module, as they got to know the needs of the participants better. Here again the issue of a standardized, versus an individualized program was raised. Discussion with staff raised the possibility that a pool of experiential exercises could be designed from which specific exercises would be drawn for each individual. Assessment of these exercises would then be made

on the basis of ratings by the staff and/or other participants depending on the nature of the exercise. Some exercises, such as going into a store and buying something could simply be rated as pass/fail depending on whether the person succeeds or not, while others might require a more complex judgment concerning the "smoothness" or ease with which the person functioned.

DISCUSSION AND RECOMMENDATIONS

After analyzing the New Options Program, there remained a number of ambiguities and unanswered questions about the goals and functioning of the program. It was therefore decided to have a staff retreat to explore that. Some of the issues that surfaced during this meeting have already been discussed. In general, a great deal of importance was attached to the field exercises and the personal contacts participants have with community consultants and staff. This was not to say that the information content of the program was not considered important: but for the consultant, at least, there was a strong feeling that what the program offers is a set of experiences which allow participants to try new ways of doing and thinking about things; facilitated by seeing others who have already achieved a fulfilling life-style. Within this framework, the information content and module structure provides a background for the field exercises.

Given this logic, the core and structure of the program should be the set of experiences offered rather than the module structure. The consultant had already pointed out the overlap in modules and had recommended that several modules be combined under new titles. The idea that emerged however,

was to begin structuring the field experiences much more closely and to list those experiences that were considered essential along with the reasons why they were essential. This led to the concept of creating a set of specific goals for each participant on each field trip, and to assess his or her performance in meeting these goals. This meant that the functions served by each module would now be integrated around a set of field experiences. The information content of the modules i.e., talks by experts, panel discussions, and small group discussions would continue to be a part of the program. In addition, these formats would be used much more consciously to prepare for field trips and to provide "debriefing" after the experiences. This solution offers an advantage in that it requires the staff to conceptualize why they have been providing certain experiences and because it allows a way to individualize the program while retaining a group structure. This is achieved by not only taking the group on a field trip, but by having different goals and exercises for participants within that structure.

Another issue raised in the retreat deserves special mention. It was noted that certain staff members have been fulfilling the special role of being available to participants on an informal basis for discussions in the hallways, while playing pool and so on. The informal nature of these contacts often provides a way for participants to approach a sensitive or important area in a casual, low anxiety fashion. A person who might never make an appointment for an interview, or knock on a door, might find himself or herself talking about something important, if it arises out of a friendly conversation on some other topic. The importance of such informal contacts should be stressed, as it is in the theraputic community model. It is

recommended that the importance of these activities be acknowledged by formally making it a part of the program in terms of a job description, along with the appropriate time and money commitments.

In conclusion, the consultant feels that the great impact of the New Options program rests on the variety of personal contacts with staff and consultants, and on the field experiences offered to its participants. Specific information is seen as having a secondary role. It is not always easy to separate information from experience. In fact, there may not be any reason to do so. It should be realized however, that the program probably cannot be packaged in the form of a catalogue of information, but instead must be described in terms of the ways in which the staff and community consultants interact with the participants, and by describing the ways in which the many field experiences widen the horizons of the participants. This also means that assessment of the program's functioning cannot be a simple matter of measuring information learned, but must recognize the learning that goes on as a person sees other disabled people coping effectively with the environment. Here again it will prove difficult to separate out any specific experiences and say what its impact was. Instead, it must be recognized that it is the buildup of a series of such experiences that produces the effect of the program. If the module system is dropped, then it will no longer be useful to think in terms of assessing the impact of individual modules - instead the participants' success in performing certain designated tasks can be measured along with their ability to expand their thinking about goals and ways to meet those goals. This approach seems to me to give the best representation of the way the program actually functions in expanding and enriching the activities of its participants.

APPENDIX

The following is a series of assessment techniques based on the present module system. Most will still be applicable if the experiential-based system is used. In general, participants should perform each assessment task before and after completing the relevant module or experiences, and the amount of improvement noted. A criterion level of performance should be established by the staff. If participants reach this level in the pre-test then there is no point in having them go through the module or experience.

FINANCIAL MANAGEMENT

1. Make a complete, detailed budget based on expectations of how you will be living a year from now. List all relevant sources of income and expense. Also include a description of all agencies or services which might be relevant to your situation and how you go about contacting them. Include long-range financial planning.

   SCORING: This may be done on a pass/fail system or the module leader may assign a score based on his or her judgment of how complete the budget is. Arithmetic should be checked.

PROBLEM SOLVING

This module should be dropped and the techniques integrated with other modules. If it is retained, then participants may be scored on whether they can list the steps in problem solving.

SEXUALITY

Sections I and IV of the Derogatis Sexual Functioning Inventory may be used for sexual attitudes. Questionnaires from the TIRR Sexual Workshop may also be relevant.

Specific items covering the effects of SCI, stroke, etc. on sexual functioning may be created by the module leader. A pool of items should be created for all disability groups and the items specific for a particular participant would be drawn from this pool.

People may be asked to give their expectations for how they will be functioning sexually in the future (with who, how often, how satisfied, etc.). The module should have the effect of raising these expectations.

MEDICAL

1. List all the medical problems relevant to your disability group, how you recognize them, what you do about them.

2. What plans would you make for receiving routine and emergency medical care in your community?

The module leader should have a list of the relevant medical problems for each disability group and score the responses from this list. The scoring will naturally be based on the material actually covered in the module.

VOCATIONAL

1. List your short term and long term vocational goals. Give the steps necessary to reach each goal along with the anticipated obstacles and what you plan to do about them.

   SCORING: Participants should be able to give a longer and more reasonable list of goals after the module and should have a better understanding of the steps necessary to reach their goal (such as educational requirements). The module leader will have to score the task on his or her judgment of how complete and realistic the result is.

HOME MANAGEMENT, LIVING ARRANGEMENTS, LEISURE, MOBILITY, AND FUNCTIONAL SKILLS

1. The specific information content of these modules is moderate to low, and from an assessment point of view they seem to be dealing with very similar issues of how well the person gets around, manipulates his environment, makes use of resources and so on. It would seem best to have the entering participants make a list of the areas of functioning that now give them trouble (such as driving, manuvering wheelchair, cooking, going to stores and so on). They can then list the goals they have for the New Options program. Their performance in achieving these goals can then be rated by the staff.

2. Participants may be asked to describe the sources of information they would use in selecting equipment, or learning about community resources. They should be able to list the steps to use in visiting new settings or using different forms of transportation such as planes or buses.

3. The field trips will provide many opportunities for behavioral ratings of

the participants' performance. This assessment should be utilized to decide if the module is working (and thus helping the person). It will be necessary to avoid having the participant feel anxious about having his or her performance rated. This can be handled through appropriate feedback and by minimizing the obtrusiveness of the rating procedure.

ATTENDANT MANAGEMENT, SOCIAL SKILLS, AND CONSUMER AFFAIRS

1. These modules all deal with social skills and are similar to these just presented in that the purpose of the modules is to develop skills rather than knowledge. Performance in these areas is best assessed by behavior ratings on the field trips or by role playing. For instance, interviewing, hiring and firing an aide can be role-played using staff or real aides. Job interviews, social occasions, and so on can be effectively modeled and ratings obtained. Here again, it will be important to minimize anxiety about the rating process. It will probably be a good idea to explain to all entering participants that evalution of the effectiveness of the modules will be continuing throughout the program.

2. Questions on the legal rights and responsibilities of various disability groups may be created by the module leader.

PROCEDURAL NOTES:

Many of the assessment techniques just outlined include staff ratings of participant's behavior. Such ratings are notoriously subject to rater expectations, biases and pre-judgments. These are best minimized by using standardized check lists and using very simple criteria of success. The following system might be used: (1) prepare a set of desired behaviors for each participant based in his goals for the six week period. This might include such tasks as getting in and out of a car, curb-jumping, buying something in a store, asking a stranger for directions, using a pay phone and so on. Different lists might be used for the different settings visited on the field trips. (2) The simplest rating to use would be whether the person does or does not perform the tasks. This simple pass/fail system should be used whenever possible. If a more complex judgment is required to rate degree of success, or the ease with which a person performs the task, the smallest number of choice points possible should be used.

It should be kept in mind that the purpose of these assessment activities is to gather information on the usefulness and effectiveness of various parts of the program for use by the staff. This information can be used in future planning and as a tool for assessing the progress of the participants. It is of only secondary importance in convincing some outside party of the effectiveness of the program since this will be done primarily by the overall pre and post measures of the graduate's community performance. Nevertheless, it is important to document what the program actually does, i.e., what the participants actually experience, if the nature of the program is to be made clear to outsiders. This documentation has the added benefit of clarifying how the system functions for the staff, so that they may more readily determine if it is functioning as they would wish it to. Some such assessment effort should be an ongoing part of the project.

OTHER MEASURES

The following paper-and-pencil tests may be useful in assessing attitude changes. They are more likely to be useful in measuring the overall impact of the program than the effects of individual modules.

1. Rotter's Internal-external locus of control scale:

   Rotter, J.B. Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs, 1966, 80 (1Whole No. 609).

   29 two-choice items

2. Cattel's 16PF

   187 three-choice items, takes about 30 minutes. Easy to score with independent factors. Gets at personal orientations and attitudes towards the world and other people.

3. Shostrum's Personal Orientation Inventory

   Shostrum, E. EITS Manual for the Personal Orientation Inventory. San Diego, California (92107): Educational and Industrial Testing Service, 1966, supplemented 1968.

   150 two-choice items getting at self-acutalization, self acceptance and other related concepts. 30-45 minutes